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ADAMANTINOMA OF THE MANDIBLE

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Non-malignant tumours can grow to enormous size if permitted to do so. The case here recorded shows the largest adamantinoma of the jaw we have encountered, and it is placed on record simply to show what a tumour of this nature can really do if permitted to grow unchecked. The history is of interest.

CASE REPORT

A.T., a Nama-Bushman male of 30, was admitted to Groote Schuur Hospital on 13 April 1955 complaining of a lump in the mouth and face which had been present for at least 16 years. The patient, who was a hunter and herdsman, was not a good witness.

At least 16 years before, the mass started to grow from the gum margin in the region of the left lower molar teeth. There has never been any sudden increase in size but growth took place at a uniform rate. The mass interfered a little with his mastication but, all in all, he managed to eat very well. He had lost a fair amount of weight, and felt very weak. At no time had there been any pain.

On numerous occasions ulceration inside the mouth has occurred and the lesion had bled profusely. Because of the patient's isolated existence in the wild and isolated country where he lived, such medical opinion as he had managed to consult could not offer him any surgical treatment.

On examination, it was seen that an immense mass grew out of the mouth and occupied the position of the mandible (Figs. 1 and 2). The skin over the cheeks had stretched and given way so that sinuses had formed, discharging blood-stained necrotic material. Inside the mouth similar superficial necrosis had taken place, and there was a constant dribble of blood-stained, offensive saliva. The lesion on palpation proved to be within the mandible itself. It was not uniform in consistency, being mainly fibrous hard with fluctuating areas, and egg-shell crackling was observed in some parts. The tongue, soft palate and maxilla were not involved and the submaxillary and submental glands, although enlarged and adherent to the mass, had not become adherent to the skin. The trachea was central and the pulse and blood pressure were normal. Unrinalysis was normal but examination of the blood showed a haemoglobin content of 3·8 g.%. An X-ray taken was reported on as follows:

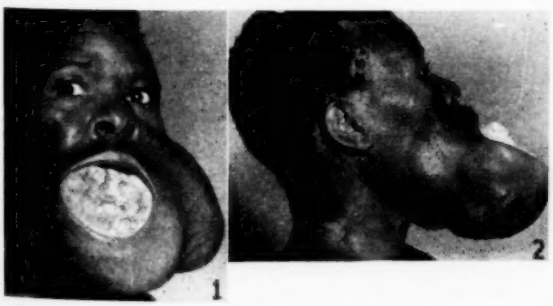
'The mandible, excluding only the ascending ramus of the right side, shows an expanding process which has extended into the soft tissues and presents a honeycombed structure too extensive for the usual adamantinoma.'

The radiological appearance of a typical adamantinoma is that of multiple clear cyst-like spaces, originally single and later becoming multiple. Calcification in a non-infected case does not occur, but once the tumour has broken out of the bone or has become infected, calcification becomes apparent. The case in point shows this calcification to a marked degree (Fig. 3). Once it is recognized that adamantinoma can grow to a very large size, size alone need not negative the diagnosis.

The Wassermann reaction was negative. Smears from the sinuses on the face showed no actinomyces. The pre-operative diagnosis was adamantinoma and it was decided to excise the tumour.

By 16 April 1955 6 pints of packed cells had been administered and this raised the haemoglobin level to 13 g.%.

Owing to the distortion of the parts, an intratracheal anaesthetic was induced with difficulty, but Dr. C. S. Jones with great skill managed to insert an intratracheal tube. Operation was commenced by making an incision which started below the inferior mandibular margin, extended across the mid-line to the opposite side, and ended below the right ear. A vertical incision in the mid-line joined this first incision and split the lower lip. After some dissection the external maxillary vessels were found and tied, and after still further dissection a plane of cleavage was found at the inferior border of the mandible. On the left-hand side the growth had extended into the coronoid process, and the mandible was therefore disarticulated from its temporomandibular articulation. On the right side it was possible to see that the tumour had not extended into the coronoid and condyloid processes so that the ascending ramus of the mandible could be divided horizontally clear of growth. Careful dissection under the mass displayed the inferior alveolar vessels, which were cut and tied. The whole mandible



Figs. 1 *and* 2. The patient on admission.

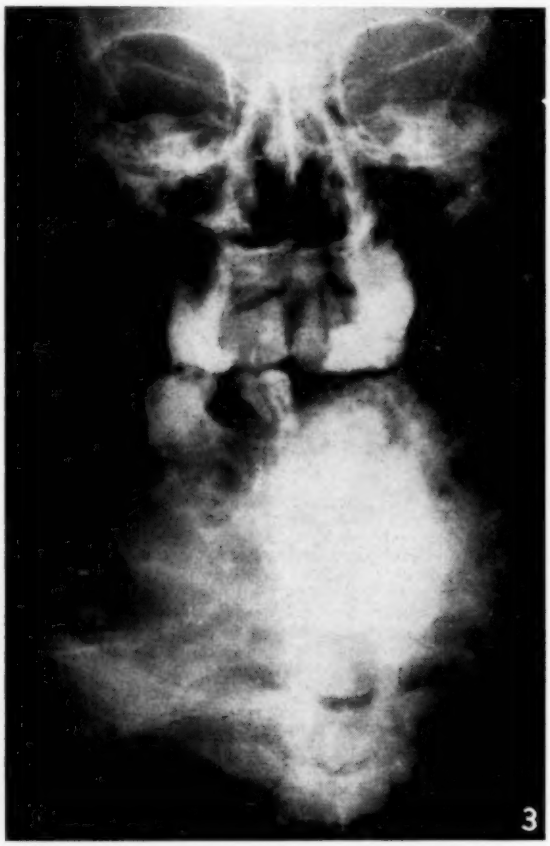


Fig. 3. X-ray of jaw.

could then be removed, leaving only the right condyloid process *in situ*, with a stump of descending ramus of the mandible attached. As there was a large amount of superfluous lip present, the left half of the lower lip was excised and the skin edges brought together. The mucous membrane of the mouth was stitched with catgut. Finally a tracheotomy was performed just below the thyroid isthmus.

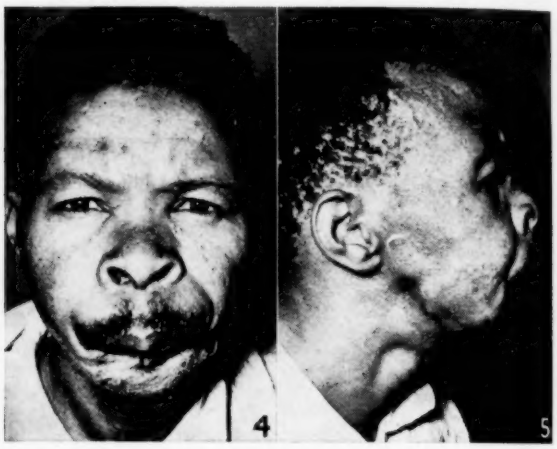
The operation took 4 hours and at its conclusion the systolic blood pressure, which was originally 120 mm. Hg., had fallen to 60. However, 4 pints of blood were given during the operation and the condition rapidly returned to normal. The patient was returned to bed and several hours later his blood pressure had returned to its pre-operative state. The pathologist's report read as follows:

Specimen consists of mandible which has been excised through the tempro-mandibular joint on the left side, while on the right side the superior ramus has been bisected above the angle. Arising from the mandible and causing gross distortion of the teeth is a large, lobulated, fairly well-encapsulated tumour measuring $20 \times 10 \times 7$ cm. On section the tumour has a firm white fibrous appearance, with numerous cystic areas containing thick yellowish fluid. Histological examination shows the typical features of an adamantinoma.

Post-operative convalescence was uneventful, the patient being out of bed within 48 hours and the tracheotomy tube being removed on the 5th day. He was fed with a duodenal tube for 3 days but very quickly learnt to eat and to take soft foods.

On 19 September 1955 Mr. N. Petersen and Mr. David S. Davies, of the Department of Plastic Surgery, took a bone graft from the left iliac crest, split it into 3 parts and wired the 3 parts together to form a curved strut. An incision was made submentally in the line of the previous scar and the skin undermined, great care being taken not to break through the healed mucosa into the mouth. The new mandible was fitted into place and one end was tucked up against the re-exposed stump of the original right mandible while the other was permitted to lie free in the region of the empty left condyloid fossa.

A drain was inserted. Once again the post-operative course was uneventful. Serous drainage persisted for 2-3 weeks but dried up spontaneously. It was felt that more could be done to improve this man's appearance, and in December 1955 Dr. David Davies Jr. operated and inserted a piece of bone subcutaneously into the chin to improve its appearance and removed several of the upper teeth to improve the appearence of the projecting mouth. It was now felt that no more should be done for this man and he was permitted to go back to South West Africa, comfortable and able to take his food with ease. (Figs. 4 and 5).



Figs. 4 *and* 5. The patient on discharge.

PATHOLOGY

Adamantinoma has long been known under various names. It is an epithelial tumour which is said to arise from a tooth follicle, more particularly its ameloblastic layer; to account for the absence of enamel in the tumour it is said to originate before the enamel organ develops. It has been classified as an epithelial odontome by Bland-Sutton[1] and, although it is usually described in the maxilla or mandible, cases have been recorded in other bones.[2] The tumour more commonly arises in the mandible than in the maxilla and is more frequent among the non-European races than the European. It grows within the bone and expands into a series of cyst-like spaces. These cysts are lined with small cells which take up the haematoxylin stain rather deeply and are very typical. Metastases are rare but, once the tumour breaks out of the bone and invades the surrounding tissues, glandular metastases may occur. Sometimes the cystic areas are filled with solid tumour and among the small highly-staining cells may be found numerous giant cells. The name 'benign giant-cell tumour' has, for this reason, been applied to the condition.

The microscopic appearance of the tumour, its resistance to radiotherapy while within the bone and its relative radio-sensitiveness once it has broken out, as well as its slow progression and the rarity of glandular metastases, recall

very strongly the appearance and genesis of basal-cell carcinoma.

TREATMENT

Radiation therapy has an uncertain effect on adamantinoma. This effect, as one would expect, is better when the tumour has broken out of the bone and has invaded the adjacent tissues. Regression of the process can then be noticed, but this regression is usually temporary. Surgical exterpation is the treatment of choice[3, 4] and since an adamantinoma will always grow if permitted to remain without treatment, the sooner this is undertaken, the less mandible will have to be sacrificed. Scraping and evacuating the tumour never achieves any permanent success and, when excision is done, the line of section of the bone need be only just clear of the tumour. If very small sections of the mandible need to be removed, the ends may be allowed to fall together and union will take place with a certain amount of distortion. Larger sections, however, will require a binding bone graft to maintain the arch of the jaw. Still larger removals, of which the case described is an extreme example, will require large bone grafts and plastic surgery. In all instances, clearance of all the teeth of the lower jaw should be performed and dental occlusion restored with the assistance and cooperation of a dental surgeon.

SUMMARY

1. A case of a large adamantinoma of the mandible is recorded.
2. It was removed by operation.
3. Several plastic operations were necessary to restore the jaw and improve the patient's appearance.

I should like to thank Messrs. N. Petersen, F.R.C.S. and D. S. Davies, F.R.C.S., of the Department of Plastic Surgery, for their very kind cooperation in restoring this man to a useful activity. I am also grateful to Rev. Fr. Jaeger, O.M.I. of the Catholic Mission, Kokasib, South West Africa, for information about the patient's ancestry, history and way of life. Mr. B. Todt, of the Photographic Department, Groote Schuur Hospital, kindly took the pictures.

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VAN DIE REDAKSIE

DIE WOODSTOCK-TREINRAMP

Die onlangse treinongeluk by Woodstock het skielik 'n groot las op verskeie van die hospitale in die Kaapse Skiereiland gelê. Twee treine met kantoorwerkers op pad huis toe na hulle dagtaak, het met mekaar gebots en die dood van 18 mense veroorsaak en 75 beseer. Die wyse waarop met hierdie gevalle gehandel is en die gladde manier waarmee hulle van die terrein van botsing na die hospitaalsale vervoer is, het baie daartoe bygedra om die lyding van die beseerdes te lenig.

Die oorsake van die 18 sterfgevalle sal sorgvuldige ontleding vereis. Volgens die eerste en onoffisiële verslae beskikbaar, skyn dit of verskeie persone gesterf het as gevolg van deurboring en ander beserings deur houtsplinters van die waens. Ten spyte van die aanbevelings wat gedoen is na verskeie spoorwegongelukke in die verlede dat waens wat slegs van staal gemaak is, gebruik behoort te word daar hulle by verre die veiligste is, is ons nog glad nie naby die roetinegebruik van die staalspoorwegwa nie; dit sal nodig wees om hierdie eis vir die veiliger tipe voertuig te herhaal.

Dit veroorsaak groot druk op enige hospitaal om te staan te kom teenoor groot getalle ernstig-beseerdes. Treinbeserings is baie selde gering, daar die magte daarby betrokke en die skielike manier waarop die treine tot stilstand gebring word, die menslike liggaam aan ernstige botsing blootstel.

Die feit dat dit binne 48 uur moontlik was om in die publieke pers aan te kondig dat al die pasiënte (behalwe een) buite gevaar verkeer het, en die sekere wete dat, met antibiotika, infeksies van ope breuke minimaal in getal sou wees en, indien dit wel geskied, dit klinies van min betekenis sou wees, is 'n weerspieëling van die vooruitgang op die gebied van traumatiese chirurgie gedurende die afgelope 2 dekades. Só groot was hierdie vooruitgang en tot so 'n mate het die kliniese beeld verander, dat dit vandag algemeen aanvaar word, beide by oorlogschirurgie en by burgerlike traumatiese chirurgie dat, indien die pasiënt lewe totdat hy behoorlikie mediese sorg kan ontvang, sy lewe gered sal word. Die reppngsyfers het 'n gestadige en bestendige verbetering getoon van minder as 40% gered gedurende die Eerste Wêreldoorlog tot 97% gered gedurende die Koreaanse oorlog.[1] Die sterfgevalle het feitlik almal op die oomblik van besering of onmiddellik daarna voorgekom, en tot so 'n mate is die prognose van besering verander, dat die grootste gevaar by 'n gebreekte dybeen vandag nie meer infeksie, slegte aangroeiing of belemmerde werking is nie, maar daardie voormalige kliniese seldsaamheid, vet-embolie; op sigself dien hierdie feit as 'n standaard van die sukses van moderne traumatologie.

'n Mens kan nie beter doen as om 100% van die beseerdes te red nie, en sover dit die red van lewens aanbetref, skyn dit of ons baie na daaraan is om die verwondes op die allerbeste

EDITORIAL

THE WOODSTOCK RAILWAY DISASTER

The recent train accident at Woodstock threw a sudden maximal load onto several of the hospitals in the Cape Peninsula. Two trains carrying office workers home after the day's work came into a collision which caused the deaths of 18 people and injured 75. The way these cases were handled and the smoothness of this handling from the site of the smash to the wards of the hospitals did much to mitigate the sufferings of the injured.

The causes of the 18 deaths will require careful analysis. From first and unofficial reports available, it seems that several died as a result of impalement and other injuries inflicted by wooden splinters from the coaches. In spite of the recommendations that have been made after several railway accidents in the past that all-steel coaches only should be used, because these are by far the safest, we are still a long way from the routine use of the all-steel coach; it will be necessary to reiterate this demand for the safer type of vehicle.

It is a great strain on any hospital to be faced with a large number of seriously injured. Train injuries are very seldom minor injuries, for the size of the forces involved and the suddenness of the stopping exposes the human body to impact of great magnitude.

The fact that within 48 hours it was possible to announce in the public press that all the patients (except one) were out of danger and the certain knowledge that, with antibiotics, infections of compound fractures will be minimal in number and, should they occur at all, will be of minor clinical significance, is a reflection of the advances made in traumatic surgery over the last 2 decades. So great have these advances been and so much has the clinical picture altered, that it is generally accepted today both in war surgery and in civilian traumatic surgery that, if the patient can only be brought alive under proper medical care, his life will be saved. The salvage figures have shown a steady and constant improvement from less than 40% saved in World War I to 97% saved in the Korean War.[1] The deaths almost all occurred at the moment of injury or immediately after, and so greatly has the prognosis of trauma been altered that the greatest danger in a fractured femur today is no longer infection, mal-union or impaired function, but that former clinical rarity, fat embolism; this fact alone is a gauge of the success of modern traumatology.

One cannot do better than save 100% of the injured and, so far as life-saving is concerned, it seems that we are

wyse te behandel. Opdat ons nie uitermate selfvoldaan word nie, sal dit wenslik wees om aandag te skenk aan die verbetering van eerstehulp-metodes. 'n Ontleding van die oorsake van sterfgevalle by sulke rampe mag toon dat ons 'n eenvoudige, maklik-aanwendbare vorm van terapie vir die vertraging van chirurgiese skok, indien nie die verhoeding daarvan nie, bitterlik nodig het.

1. Holmes, R.H. (1953): *Recent Advances in Medicine of Military Importance*. Walter Reed Army Medical Center, Washington, D.C.

indeed coming close to perfection in handling the wounded. Lest we become dangerously complacent it will be well to give attention to improvement of first-aid methods. An analysis of the causes of death in such disasters may well show that we are sorely in need of a simple, easily administered form of therapy for the postponement, if not prevention, of surgical shock.

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KWAADAARDIGE MELANOOM

Kwaadaardige melanoom is 'n seldsame toestand en vorm slegs 3% van velkankers, maar die besonder kwaadaardige vermoë daarvan en verwoestende eienskappe van verspreiding, maak dit die allergevaarlikste van kwaadaardige gewasse. Gepigmenteerde velgewasse kan geklassifiseer word as verbindings-, saamgestelde, binnehuidse en blou moedervlekke, volgens die posisie van die moedervlekselle in verhouding tot die opperhuid en die onderhuid. By die *verbindingsoort* verkeer die grondlaag van die opperhuid by sy verbinding met die onderhuid in 'n toestand van ongemaklike verhouding tot die omliggende sellulêre strukture. Die *saamgestelde* soort word gekenmerk deur die aanwesigheid van moedervlekselle beide in die verbindingstreek en in die onderhuid, en dit is die verbindingsfaktor wat aan beide hierdie groepe hulle potensieel uitbarstende hoedanigheid verleen. Beide die binnehuidse en blou moedervlekke, daar hulle geheel en al binne-in die onderhuid geleë is, ondergaan baie selde kwaadaardige verandering. Afgesien van die aanwesigheid van sellulêre aktiwiteit (wat histologies herken word aan kern-anaplasie, hiperchromatisme, toename in kerngrootte en die aanwesigheid van mitotiese vorms[1]), word kwaadaardige degenerasie ook aangedui deur die voorkoms van sel-neste by die opper-onderhuidverbinding, atipiese en pleomorfiese selle, aanduiding van indringing, en ontstekingsveranderinge wat nie deur besering verklaar kan word nie.[2]

Klinies kan verbindingsmoedervlekke op enige gedeelte van die vel aangetref word, maar soos deur sir Stanford Cade[1] benadruk, is moedervlekke op die handpalms, voetsole en geslagorgane altyd van die verbindingstipe. Byna alle gewone moesies behoort tot die binnehuidse soort en Cade het die aandag gevestig op die seldsaamheid van kwaadaardige verandering by harige moesies, en stel voor dat verlies van hare by so 'n moesie die aanwesigheid van 'n saamgestelde faktor aandui met aktiwiteit van die verbindingstreek. Die blou moedervlek, wat na bewering van neurogeniese oorsprong is, word gewoonlik op die gesig, en rugkant van hande en voete aangetref en ondergaan selde kwaadaardige degenerasie. Alhoewel 90% kwaadaardige melanome op die grondslag van 'n vooraf-bestaande verbindingsmoedersel ontstaan, ondergaan selgs 'n klein persentasie van hierdie moedervlekke werklik karsinoomagtige verandering.[3] Nogtans is dit geregverdig om die aanwesigheid van moedervlekke op die handpalms, voetsole en geslagorgane met 'n mate van kommer te bejeën, aangesien hulle altyd van die verbindingssoort is, en die verstandige internis sal aanraai dat hulle voor die puberteitsjare verwyder word. Gevaartekens is die voorkoms van bloeding, òf spontaan òf as gevolg van die geringste besering, 'n kleurverdonkering, knopperigheid, en

MALIGNANT MELANOMA

Malignant melanoma is a rare condition, comprising only 3% of skin cancers, but its high malignant potential, and devastating powers of dissemination, make it the most dangerous of all malignant neoplasms. Pigmented skin-tumours may be classified as junctional, compound, intradermal and blue naevi, according to the situation of the naevus cells in relation to the epidermis and dermis. In the *junctional* variety, the naevus cells lurk in the basal layer of the epidermis at its junction with the dermis in a state of uneasy equilibrium with the surrounding cellular structures. The *compound* variety is characterized by the presence of naevus cells both in the junctional area and in the dermis, and it is the junctional element which confers on both of these two groups their potentially explosive properties. Both the *intradermal* and *blue naevi*, situated as they are entirely within the dermis, very rarely undergo malignant change. In addition to the presence of junctional cellular activity (recognized histologically by nuclear anaplasia, hyperchromatism, increase in nuclear size and the presence of mitotic figures[1]) malignant degeneration is also indicated by the occurrence of nests of cells at the dermo-epidermal junction, atypical and pleomorphic cells, evidence of invasion, and inflammatory changes which cannot be accounted for by trauma.[2]

Clinically, junctional naevi may be found on any part of the skin but, as stressed by Sir Stanford Cade,[1] naevi on the palms, soles and genitalia are always junctional in type. Nearly all of the common moles are of the intradermal variety, and Cade has drawn attention to the infrequency with which hairy moles undergo malignant change, and suggests that the loss of hair by such a mole indicates the presence of a compound element, with activity of the junctional part. The blue naevus, said to be of neurogenic origin, is found most commonly on the face and dorsum of the hands and feet and rarely undergoes malignant degeneration. Although 90% of malignant melanomas arise on the basis of a pre-existing junctional naevus, only a small percentage of these naevi actually undergo carcinomatous change.[3] Nevertheless it is justifiable to regard with some apprehension the presence of naevi on the palms, soles and genitalia, as these are always of the junctional variety, and the wise physician will advise their removal before puberty.

die verskyning van gepigmenteerde kolle buite die omvang van die moedervlek.

Daar is sommige gepigmenteerde letsels by kinders wat 'n verontrustende mikroskopiese voorkoms toon, maar wat nogtans 'n onskuldige kliniese verloop volg. Hulle is die sogenaamde ‚jeugmelanome'. Spitz en Allen[3] is die mening toegedaan dat twee-derdes van hierdie letsels volgens hulle mikroskopiese voorkoms gediagnoseer kan word, terwyl die orige derde histologies ononderskeibaar is van volwasse melanokarsinoom. Jeugmelanome ondergaan wel af en toe kwaadaardige degenerasie, maar volgens alle gegewens is dit uiters seldsaam en, om hierdie rede, behoort hierdie letsels, waar hulle voor die puberteitsjare voorkom, altyd deur behoudende chirurgie behandel te word.

Cade[1] het onlangs die lot van 132 pasiënte, wat aan kwaadaardige melanoom gely het, hersien. Die algemeenste plekke van voorkoms was die onderste ledemaat, veral die voet en enkel (wat ook die algemeenste ligging vir verbindingsmoedervlekke is), die kop en nek, die romp en die boonste ledemaat, in daardie volgorde. Een-sesde het binne die eerste jaar, en twee-derdes binne die eerste twee jaar gesterf. Slegs 14 pasiënte het 5 jaar of langer geleef, en van hierdie, het 'n verdere 9 nog tekens van siekte getoon.

Dit word nou algemeen aangeneem dat die regte behandeling van die primêre gewas breë uitsnyding is, en onder hierdie omstandighede is veloorplanting byna altyd nodig. Cade het getoon dat onvoldoende behandeling van die primêre gewas, deur metodes wat hy ‚lapwerk' noem, bv. branding, elektrolise en diatermie, die pasiënt se kanse op oorlewing ernstiglik benadeel, en dat dit ten sterkste afgekeur behoort te word. Dieselfde geld vir onvolledige uitsnyding vir diagnostiese doeleindes, wat op sigself 'n dodelike prosedure is. Met doeltreffende behandeling van die plaaslike letsel het 42% van die pasiënte in Cade se reeks geen lokale hervatting in die omtrek van die primêre letsel gehad nie, en dit moet vergelyk word met die ontwikkeling van lokale hervatting by 73% by wie die behartiging van die primêre letsel ondoeltreffend was. Die belangrikheid wat plaaslike behandeling op die uiteindelike prognose uitoefen, is op 'n oortuigende wyse deur Preston *et al.*[4] gedemonstreer. Hulle het gevind dat waar die aanvangsbehandeling van die primêre letsel nie geslaag het om plaaslike hervatting te verhoed nie, slegs 2% pasiënte langer as 5 jaar geleef het. Die algemene opvatting is dat die streekkliere verwyder behoort te word, selfs al is daar geen kliniese aanduiding dat hulle aangetas is nie. Preston *et al.* het 'n reeks van 48 pasiënte hersien (47 met streekklier-matastase) by wie die primêre letsel en streekkliere verwyder is, en 'n 10-jaar-oorlewingssyfer by 2% aangetref. By 33 pasiënte is slegs die primêre gewas verwyder en in hierdie groep was daar niemand wat langer as 10 jaar geleef het nie. Cade is egter die mening toegedaan dat waar die streekkliere klinies nie betrokke is nie, hulle slegs verwyder behoort te word indien reseksie in kontinuïteit met die primêre letsel uitvoerbaar is. Hy verdoem die verwydering van 'n strook vel vanaf die primêre gewas in die voet of hand tot by die streekkliere as ‚'n nuttelose gebaar wanneer die anatomie van die limfvate in aanmerking geneem word.' Daar is geen eenstemmigheid van mening aangaande die behartiging van melanoom by swangerskap nie. Lewis[5] meen dat daar 'n einde aan swangerskap gemaak behoort te word, terwyl Cade, alhoewel hy aanvaar dat die prognose erger gemaak word, nie saamstem dat beëindiging die vooruitsig enigsins sal verbeter nie.

Danger signs are the occurrence of bleeding, either spontaneously or from the slightest trauma, a deepening in colour, nodularity, and the appearance of pigmented spots beyond the periphery of the naevus.

There are some pigmented lesions in children which present an alarming microscopical appearance, but none the less pursue a benign clinical course. These are the so-called 'juvenile melanomata'. Spitz and Allen[3] are of the opinion that two-thirds of these lesions can be diagnosed on their microscopical appearance, the remaining third being indistinguishable histologically from adult melanocarcinoma. Juvenile melanomata do occasionally undergo true malignant degeneration, but by all accounts this is excessively rare and, for this reason, these prepubertal lesions should always be treated by conservative surgery.

Cade[1] has recently reviewed the fate of 132 patients suffering from malignant melanoma. The commonest sites were the lower limb, especially the foot and ankle (which is also the commonest site for junctional naevi), the head and neck, the trunk, and the upper limb, in that order. One-sixth died within the first year, and two-thirds within the first 2 years. Only 14 patients survived 5 years or more, and of these a further 9 still showed evidence of disease.

It is now generally agreed that the correct treatment of the primary growth is by a wide excision, and under these circumstances skin grafting is nearly always necessary. Cade has shown that inadequate treatment of the primary growth by methods which he calls 'tinkering', e.g. cautery, electrolysis and diathermy, gravely prejudices the patient's chances of survival, and is to be severely condemned. So also is incomplete excision for diagnostic purposes, which in itself is a deadly procedure. With adequate treatment of the local lesion, 42% of patients in Cade's series remained free from local recurrence in the vicinity of the primary lesions, and this must be contrasted with the development of local recurrence in 73% of patients in whom the management of the primary lesion was inadequate. The importance of local treatment in affecting the ultimate prognosis has been convincingly demonstrated by Preston *et al.*,[4] who found that, where the initial treatment of the primary lesion had failed to prevent local recurrences, only 2% of patients survived 5 years. The opinion is generally held that the regional nodes should be removed even in the absence of clinical evidence of involvement. Preston *et al.* reviewed a series of 48 patients (47 with regional-node metastases) in whom the primary lesion and regional nodes were resected, and found a 21% 10-year survival. In 33 patients the primary tumour alone was removed, and in this group there were no 10-year survivors. Cade, however, is of the opinion that where the regional nodes are not clinically involved, their removal should be undertaken only if resection in continuity with the primary tumour is feasible. He condemns the removal of a strip of skin from the primary growth in the foot or hand up to the regional nodes as 'a futile gesture if the anatomy of the lymph vessels is kept in mind'. There is no unanimity of opinion regarding the management of melanoma in pregnancy. Lewis[5] feels that pregnancy should be terminated, while Cade, although accepting that the prognosis is made worse, does not agree that the termination will in any way improve the outlook.

Whether ultra-radical surgery in the shape of hind-quarter

Of ultra-radikale chirurgie in die vrom van agterkwart- of voorkwart-amputasie ooit geregverdig is, is nog steeds 'n saak van spekulasie. Hierdie skendende operasies beheer nie verspreiding *via* die bloedstroom nie, en daar is tot nog toe geen bewys dat hulle die prognose enigsins verbeter het nie.

1. Cade, S. (1957): Brit. Med. J., 119.
2. Lund. Aangehaal deur Lewis C. W. D., *loc. cit.*[5]
3. Allen, A. C. en Spitz., S. (1954): Arch. Derm. Syph., **69**, 150.
4. Preston, F. W., Powers, R. C., Clarke, T. H. en Walsh, W. S. (1954): Arch. Surg., **69**, 385.
5. Lewis, C. W. D. (1956): Ann. Roy. Coll. Surg. Engl., **19**, 156.

or fore-quarter amputation is ever justified is still a matter for conjecture. These mutilating operations do not control spread *via* the blood stream, and there is no evidence as yet that they have improved the prognosis to any significant degree.

1. Cade, S. (1957): Brit Med. J., **1**, 119.
2. Lund. Quoted by Lewis, C. W. D., *loc. cit.*[5]
3. Allen, A. C. and Spitz, S. (1954): Arch. Derm. Syph., **69**, 150.
4. Preston, F. W., Powers, R. C., Clarke, T. H. and Walsh, W. S. (1954): Arch. Surg., **69**, 385.
5. Lewis, C. W. D. (1956): Ann. Roy. Coll. Surg. Engl., **19**, 156.

THE DURBAN CONGRESS

A prominent feature of this year's South African Medical Congress, which will be held in Durban on 16-21 September, and of which we publish a notice in this issue of the *Journal* (p. 478), is the impressive list of eminent medical personalities from overseas who will be present. Besides many from England, including the Presidents of the Royal College of Physicians of London and of the Royal College of Surgeons of England, Professor Bortz and Professor Brunschwig are expected from America and Professor Wilflingseder from Austria, as well as Dr. Gelfand and Mr. Marks from Southern Rhodesia, both of whom are South African graduates. Our visitors will take a prominent part both in the plenary sessions and sectional meetings (see page 478). We have a lively recollection of the distinguished overseas visitors who so greatly enriched the last South African Medical Congress, which was held in Pretoria. This year our visitors will be attending in still greater numbers; we confidently anticipate that in future the presence and contributions of visitors to South Africa will become a regular, and valuable, feature of our Medical Congresses.

The organizers of the Durban Congress are giving great prominence to the Scientific Exhibition which together with the Trades Exhibition will constitute an important feature of Congress. The Trades Exhibition has always been much valued by Congress members, and the Association and the medical profession owe a debt of gratitude to the exhibitors, who go to great trouble and expense to give of their best in this essential feature of Congress.

Members intending to attend the Congress will do well to book accommodation without delay.

DERMATOLOGY OF THE BANTU

A SURVEY

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At present we have little general information about skin disease in the Bantu. The reasons for this, bluntly, are lack of interest, lack of sound diagnosis and lack of adequate records. Though some gross features of Bantu dermatology may perhaps emerge from the survey presented here, many years of study are still necessary to fill this gap in our knowledge. Even for the white population of South Africa we have no written account of the incidence of the commoner skin complaints.

The present study consists of a review of 600 consecutive Bantu skin cases. All were seen personally by myself during 1956 at the non-European out-patient department of the Pretoria Hospital. Some considerable sorting preceded their arrival at our out-patient service. They were all referred by the medical officer in charge of out-patients, who handled various skin cases himself (e.g. boils, obvious syphilis) and, for various reasons referred certain skin patients to other departments (e.g. surgery, paediatrics). Consequently we are unable to give any idea of the frequency of dermatoses among Bantu patients in general, added to which the hospital attendances are recorded per visit and not per case, and include visits for dressings and injections. Apart from this involuntary selection and the small size of our series, we were probably hampered as well by low numbers of return visits. This allowed me little chance of revising the original diagnosis at a later visit when necessary. However, these and other sources of error are indicated throughout, and should reveal to the reader any bias inherent in my observations.

Throughout the following statement percentages refer to percentages of the total number of cases seen, and not to percentages in any subdivision.

(*a*) ECZEMA (20%)

Seborrhoeic dermatitis of adults	7%
Seborrhoeic dermatitis of infants	2%
Eczema of the hands	2%
Atopic eczema (all ages)	2%
Follicular, grouped and lichenified eczemas	2%
Contact eczema	1·5%
Miscellaneous (scrotal, generalized eczemas)	1·5%
Nummular eczema	1%
Pityriasis alba	1%

Seborrhoeic dermatitis of adults. In this group the average age was 33 years and the sex ratio equal; and here are

classified the classical types of 'eczematide' (as described by Darier) which were seen. The lesions were mostly dry, but some exudative scalp types were seen and included. Likewise, the moist varieties suggesting relapsing impetigo of the ordinary crusted type, and the flexural fissuring type are grouped here. Several examples of sudden acute seborrhoeic dermatitis of the face were seen, in which contact dermatitis seemed likely though no contact factor was demonstrable. These acute cases are also not uncommon in European practice. Dry eczema of the sides of the neck and the elbow flexures were regularly seen, in which the clinical history was short for the current attack, but occasionally a longer history was given, and the picture blended with that of atopic eczema. Some examples of eczema of the nipples, and epilating eczema of the eyebrows are included here likewise.

Seborrhoeic dermatitis of infants was diagnosed in children who were actually all under the age of 3 months, with an onset at any time since birth. Features of impetigo were often present, with scabs on the scalp, intertriginous lesions and the fixed papules and depigmentation of chronic impetigo. Associated follicular lesions were also seen.

Eczema of the hands. The usual varieties such as the dysidrotic, nummular and infected types were seen, as in Europeans. In 400 European cases seen privately, I found that hand eczema was diagnosed in 8%, as compared with 2% in this series.

Atopic eczema was not particularly common. Included under this head are cases of infantile eczema, Besnier's prurigo, and certain chronic dry relapsing eczemas of adults which were seen. Since flexural and infected eczemas predominated, they swelled the group of seborrhoeic dermatitis rather than that of constitutional or atopic eczema.

Follicular, grouped and lichenified eczemas comprised patchy lesions of rather varied course and appearance. Some could perhaps be classed as chronic nummular eczema, follicular eczematides, neurodermatitis, chronic impetigo etc.

Contact or occupational eczema was infrequent. I am unimpressed by the role of allergens as a demonstrable cause in either black or white patients belonging to this group. In this regard the legal implications are poorly appreciated in South Africa, where as in other countries, official concepts of contact eczema are based on researches now at least 40 years old.

Scrotal eczema was complicated by great skin thickening and follicular sepsis.

Pityriasis alba. The cases under this heading are drawn variously from the follicular eczematides, cases of chronic impetigo, misdiagnosed ringworm etc. Many of these cases are sent in as lepers, an error which is all too familiar to the leprosy officers.

(*b*) BACTERIAL INFECTIONS (20%)

Impetigo and ecthyma	14%
Syphilis	2·6%
Boils and abscesses	1%
Lupus vulgaris	0·7%
Tuberculides	0·7%
Miscellaneous (including leprosy)	1%

Impetigo and ecthyma comprise the biggest single group of cases, and probably contain many conditions which would be classified differently on closer study. The text-book varieties were all seen and are included here. Pemphigus neonatorum was seen once. Cases of infected scabies are excluded, but many cases of impetigo were thought to follow insect bites. Lice played no part, however. Diphtheria of the skin was suspected on a few occasions but was not confirmed. Shaving of the scalp was a frequent cause of the onset or spread of impetigo on the head. In children many cases of scalp impetigo were seen, even with epilation from acute folliculitis, that closely resembled ringworm. Pigmentary changes were common, and pityriasiform and follicular patches, regarded provisionally as ides, were frequent. Mild ecthyma of the legs was sometimes associated with marked oedema. This was arbitrarily ascribed to concurrent malnutrition.

Syphilis was mainly seen in Bantu girls in their teens, who were less readily held back by the medical officer at out-patients. It is worth mentioning that at the Institute of Pathology Dr. J. C. Coetzee has found 20% positive reactions for syphilis in over 6,000 sera sent from the non-European hospital. Today, active syphilis has virtually ceased to exist in the white population.

Boils were seldom sent to our department.

Lupus vulgaris was seen in 7 patients during the survey, 4 of whom fell within the series itself. We have yet to see a case of lupus vulgaris in a South-African-born White person in the Transvaal. Boeck's sarcoid is very rare in the Bantu, although I have in the past seen undoubted cases. In America the Negroes seem to be affected more frequently by sarcoid.

Tuberculides were not recognized with confidence except where the small follicular type extended over the eyelids and was continuous with a focal conjunctivitis and interstitial keratitis.

Miscellaneous. Cases were seen of lepromatous leprosy, sycosis nuchae, pyogenic granuloma and perforating ulcer. Two cases of chronic pyoderma of the feet were seen, resembling Madura foot. Careful search failed to reveal any fungus, and a staphylococcus only was found. As these cases were of many years' duration, the original infecting organism may have disappeared.

(*c*) SOME INFLAMMATORY DERMATOSES (16%)

Acne vulgaris	7·5%
Urticaria	2%
Erythema multiforme	1·7%
Pityriasis rosea	1·5%
Psoriasis	1%
Erythema nodosum	1%
Lichen planus	0·5%
Dermatitis herpetiformis	0·5%
Lupus erythematosus	0·2%
Rosacea	?

Acne vulgaris. Most cases were strikingly mild, showing that the Bantu are not uninterested in trivial abnormalities. Slightly more males than females were seen, and most were in their teens or early twenties. Some relationship was noted between acne and the follicular disturbances of malnutrition. Both were seen to suppurate and also to lead to reticulated atrophic scars. Septic complications of acne were noteworthy (impetigo, cellulitis etc.), and disfiguring pigmentary changes were frequent reasons for seeking advice. Hypertrophic scarring was seen once, but severe cystic cases were not observed.

Urticaria was usually of the acute type, but one case of

chronic urticaria was seen and fully investigated without any cause being found. Natives commonly complained of a transient rash at night, which we treated empirically with antihistaminics. These might have been cases of mosquito bites.

Erythema multiforme. Isolated attacks and recurrent varieties were seen, with herpes simplex or drugs as exciting factors in some cases. We have in the past seen erythema multiforme in its severest, and fatal, forms in the Bantu. Bullous eruptions with dermatomyositis have confused us in the past in this respect. It must be mentioned that dermatomyositis in all its acute and chronic forms is not very rare in the Bantu. I saw 25 cases between 1950 and 1953.

Pityriasis rosea occurred chiefly in young adults. I have so far been unable to establish a seasonal peak in the Transvaal for this complaint, the distribution of cases in Europeans and Bantu having in my experience, been even throughout the year.

Psoriasis. All cases were in persons of pure Bantu stock, and one extensive case came from Tanganyika. The cases were all clinically typical, and we find no reason to suppose that psoriasis in a Native denotes a mixed ancestry. It is rare compared with its incidence in Europeans. Figures from my private practice show an incidence in Europeans similar to those reported from the Northern Hemisphere.

Erythema nodosum. No specific histological types were identified. Age incidence, 18-45 years. Duration, 1 month to 3 years. Males, 4; females, 2.

Lichen planus. We have in the past seen in the Bantu many unusual varieties of lichen planus, whose identification has been made easier by the work of Gougerot. ACTH has been used with benefit and has even cleared up some of the mouth lesions.

Dermatitis herpetiformis. The cases were clinically and histologically typical.

Lupus erythematosus is distinctly rare in its chronic form, although we can recall having seen several cases over the years. The acute variety has also been seen. Both varieties seem to be commoner in Whites.

Rosacea is virtually unknown in the Bantu. Two cases were considered. In one the diagnosis was highly probable but the ancestry was mixed and the other was a pure Bantu but the diagnosis was in doubt.

(*d*) INFESTATIONS (13%)

Scabies	11%
Miscellaneous	2%

Scabies. The diagnosis was clinical throughout and in no cases was the acarus sought and extracted. This meant that various follicular reactions, and virtually all cases of lichen urticatus, were included under this heading, making the apparent incidence of scabies unduly high. Some hypertrophic crusted lesions were seen in association with pellagra, though no true Norwegian cases were seen.

Other infestations. Several undoubted cases of insect-bite reactions were seen. One case each was seen of pubic louse infestation, sandworm and cutaneous bilharzia. Our experience confirms the relative rarity in the Negro of sandworm infestation, which is frequent in Europeans living in and around Pretoria. Body and head lice are occasionally seen, but are rare as causes of dermatitis. Very occasionally we see furunculoid myiasis, but it is commoner further north. Sometimes we are puzzled by cases of grouped bullae arising for no definite cause. Contact with substances derived from insects or plants may be responsible, but it is not certain what these vesicants are. Dermatoses from marine animals are prevalent around our coasts, but are not represented in my material.

(*e*) VIRUS DISEASES (7%)

Warts	2·5%
Fevers	2%
Herpes simplex	1·5%
Herpes Zoster	1·0%

Warts. A quarter of these were venereal. Plane warts show up white at times on a dark skin. The so-called plantar warts of the Bantu are discussed in section (h), under the title of plantar corns.

Fevers comprised undiagnosed chicken-pox, measles and German measles sent through to our section.

Herpes simplex was seen in all its common forms, and was diagnosed on clinical grounds alone. Primary stomatitis of infants, erosive vulvitis, etc. were included.

Herpes zoster was seen mainly on the chest in the young adult male. One case followed on a boil in the affected segment.

Molluscum contagiosum was seen once. The condition is not particularly common in Pretoria in any group of the population.

(*f*) FUNGOUS DISEASES (5%)

Pityriasis versicolor	3%
Tinea (capitis, corporis, cruris)	2%

Pityriasis versicolor. Only those cases are included under this heading where it was the presenting complaint. No cases were seen below the age of 14. Some years ago I found pityriasis versicolor in 10% of all new Native recruits for the mines coming from Portuguese territories. Those already in mine employ showed very little infection though no special treatment had been given. Regular showering was probably sufficient to cure most of the cases. The most extensive and bizarre manifestations were seen in the recruits.

Tinea capitis etc. No cases of tinea pedis were diagnosed. On reviewing the records, a complete failure has to be recorded when it came to identifying the fungus. In the cases of tinea capitis, corporis and cruris, something went wrong with all the laboratory tests made and the field remains open. We have made adequate studies in European cases, but these are not relevant here. In scalp cases, chronic and subacute impetigo was the chief source of confusion in diagnosis. Favus is still endemic in certain rural Bantu populations, but its extent amongst the urban natives is not known. I am unaware of any proven cases of favus in White South Africans but obviously they may occur occasionally.

Deep fungous infections are absent from the present series, although reference was made to Madura foot among the pyodermas (*b*). We have seen proven cases of actinomycosis, sporotrichosis and chromoblastomycosis in natives, but all are rare.

(*g*) DEFICIENCY DISEASE (5%)

Clinically identifiable deficiency disease usually means typical pellagra, with a small proportion of cases showing

phrynoderma or scurvy as well. Our patients were mainly young women of child-bearing age. The medical and paediatric sections have dealt with many other cases of a similar type. Sepsis, scabies and acne often occurred with pellagra, and there seemed to be some clinical synergism in their association. Cases of periocular and perioral pellagra were seen now and again, as well as severe stomatitis and vulvitis.

Chronic alcoholism was sometimes a predisposing cause, and a few seasonal cases were noted. The paradoxical picture of acne with gynecomastia was sometimes seen in pellagra, the important underlying change possibly being liver damage.

(*h*) MISCELLANEOUS GROUPS AND SINGLE CASES (14%)

Disturbances of pigmentation	1·5%
Porphyria	1%
Drug eruptions	1%
Light eruptions	1%
Plantar corns	1%
Hyperidrosis	0·5%
Malignant disease	0·3%
Miscellany (approx.)	8%

Disturbances of pigmentation included vitiligo, possible melanosis of Riehl's type, depigmentation of the lower lip, etc.

Porphyria. All cases were of the porphyria cutanea tarda type. One was a boy of 5 years without demonstrable liver damage, showing the acquired type with an abundance of the third isomer. In private European practice I see porphyria in 0·25-0·3% of cases.

Drug eruptions were usually from phenolphthalein.

Light eruptions. These may contain wrongly classified examples of seborrhoeic dermatitis. They were usually of sudden onset and there were no contact factors. The follow-up was inadequate in this group.

Plantar corns. In hospital these painful keratoses of the sole were usually called plantar warts. Unlike plantar warts, however, they occurred usually in males from 25-40 years of age, were largely corn-like and overlay weight-bearing bony prominences, and were associated with other keratotic disturbances on the feet; sometimes there was a thin skin round about with a cyanotic colour and hyperidrosis. The disabling pain had not been relieved by successful transplantation of the affected skin in 2 cases which we saw. We could not find any reason for the failure of this measure. The condition still needs investigating.

Hyperidrosis was associated with tender blue hyperkeratotic soles of the feet. The tender petaloid and polycyclic white plaques which one sees on the soles in this condition need further study. I have still to see some printed account of them.

Malignancy. This modest group of two cases (squamous carcinoma of the scalp and Kaposi's sarcoma) is probably not highly representative. We have still personally to see a rodent ulcer in the Bantu. This complaint occurs in 10% of European hospital skin out-patients. Malignant melanoma, Kaposi's sarcoma, squamous epithelioma and dermatofibrosarcoma are the most usual malignancies in the Bantu. Albinism in the Bantu has yielded interesting material for cancer studies, but we have had no material ourselves. We have not yet seen mycosis fungoides in the Bantu.

Miscellaneous

Erythema ab igne is seldom complained of, but one remarkable case was seen. A night watchman sitting over his brazier for 14 years developed a reticulum of hypertrophic scars as a sequel to recurrent bullae disposed along the network. Traditionally it is permitted for women to develop erythema and erythema ab igne, but in men it is a shameful sign of indolence. It is known as *dipala*. The night watchman denied that he had *dipala*, since he had acquired it not through laziness but through his occupation.

Alopecia areata is very rare. We have seen it twice in the Bantu, both cases occurring in this series. In Whites the incidence compares closely with that seen in Europe.

Varicose (*post-phlebitic*) *ulcer* was seen once. As a rule the surgeons see these cases. Gross vascular disturbances are often present.

Follicular keratoses presented some difficulty, since epidemic follicular keratosis occurred sporadically during the period of study. The differential diagnosis included follicular eczematides and anti-bilharzial (antimony) drug-eruptions.

Uncommon dermatoses comprised the remaining 2·5% of cases, and it is of no particular interest to enumerate them here.

CONCLUSIONS

Unfortunately, all comparisons have to be made with our largely unanalysed impressions of skin disease in the white South African.

Certain dermatoses are overwhelmingly common in the Bantu and are less frequent in the Whites. These are the infective (seborrhoeic) eczemas, pyodermas and scabies.

The following conditions are regularly seen in the Bantu, and are much rarer in varying degrees in the Whites: pellagra, porphyria, plantar corns, venereal warts, syphilis, leprosy and lupus vulgaris.

Europeans show the following conditions far more frequently than the Bantu: lupus erythematosus, light eruptions, atopic and hand eczema, psoriasis, tinea (all varieties) and sandworm.

The following are hardly ever seen in the Bantu, and are well-known among the Europeans: alopecia areata, anogenital pruritus, rosacea, solar keratoses, rodent ulcer, xanthelasma and xanthomatoses.

Some of the differences may depend on diet, hygiene, pigmentation of the skin, psychic make-up and hereditary disposition, but the complex factors involved in liability to disease are hardly likely to be understood without a great increase in our knowledge.

Of those diseases which are rare in both black and white races we can merely offer some impressions. We have seen all the varieties of pemphigus in the Bantu. Many keratotic disorders (e.g. Darier's disease, pityriasis rubra pilaris) have been seen in typical form in the Bantu. A variety of connective-tissue dystrophies have been noted. We have yet to see parapsoriasis *en plaques* and mycosis fungoides. Guttate parapsoriasis has been observed, however. Dermatomyositis is the commonest collagen disease, and until recently we had not seen generalized scleroderma. Granuloma annulare is known, but most uncommon in the pure Bantu.

Many minor cutaneous disturbances, such as naevi, angiomas, etc. have been passed over without comment in this survey. Their features in the Bantu await attention.

THE RESULTS OF CATARACT EXTRACTIONS AT GROOTE SCHUUR HOSPITAL, CAPE TOWN

A COMPARISON WITH RESULTS OBTAINED AT MOORFIELDS HOSPITAL, LONDON

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In 1954 E. C. Glover[1] published a report on his analysis of the cataract extractions performed at Moorfields Hospital, London, in 1949. He did so in order to supply some useful information 'partly as a comparison of extra- and intracapsular operations and partly as to the general standard of cataract extraction at such an institution as Moorfields'. It was felt that the results of a series of cases taken from the records at Groote Schuur Hospital (in this article referred to as GSH) might provide an interesting comparison and also bring to light useful information.

What follows is an analysis of the results of cases operated on at GSH during the year 1955. One hundred cases were taken at random from the European ward only, so as to rule out any possible racial differences. A follow-up of at least 3 months was insisted upon before visual results were assessed.

The operations were performed by 12 surgeons, 2 of them on the resident staff. The Moorfields series comprises 949 cases, and 22 surgeons performed the operations, of whom 10 were on the resident staff.

Needlings and linear extractions are excluded from both series.

Age Incidence

The average age was 67·5 years in the GSH series, 66·1 years in the Moorfields series.

Sutures

In the Moorfields series there were 727 cases in which no sutures were used. In the GSH series sutures were used in all cases.

Type of Extraction

In both series intracapsular, extracapsular and vectus extractions were used. The erisiphake method was used only in the GSH series. Table I shows the incidence of the methods

TABLE I. TYPE OF EXTRACTION

	Moorfields	*Groote Schuur*
Intracapsular	43·2%	63%
Extracapsular	55·2%	37%
Vectus	1·5%	2%
Erisiphake	*nil*	13%

used. Erisiphake extractions were in all cases intracapsular. 'Failed' intracapsular extractions were included in both series as extracapsular.

Complications

These are summarized in Table II and Figs. 1 and 2, which bring out the close correlation between the incidence of hyphaemata in the two series. The difference of 5% is small when one considers that more specialized ophthalmological nursing is available at Moorfields than at GSH, which is a general hospital where the nursing staff is constantly changing. Another striking feature is that in erisiphake extractions hyphaema occurred in 64% of cases and vitreous loss in 12·5%. The erisiphake series, however, is admittedly rather small.

TABLE II. COMPLICATIONS

Complication	*Incidence related to Total No. of Cases*		*Incidence related to Type of Extraction*				
			Intracapsular		*Extracapsular*		*Eris.*
	M	*GSH*	*M*	*GSH*	*M*	*GSH*	*GSH*
Hyphaema	24%	29%	*	25%	*	18%	64%
Vitreous loss	5·5%	8%	7·5%	8%	4%	8%	12·5%
Vitreous haemorrhage	*Nil*	2%	*Nil*	3%	*	*Nil*	*Nil*
Choroidal detachment	*Nil*	2%	*Nil*	3%	*Nil*	*Nil*	*Nil*
Retinal detachment	8·5%	3%	*	5%	*	*Nil*	*Nil*
R. & C. detachment	*Nil*	1%	*Nil*	1·5%	*Nil*	*Nil*	*Nil*
Prolapse iris	4·5%	4%	*	6·3%	*	*Nil*	*Nil*

* Figures not available. M = Moorfields. GSH = Groote Schuur Hospital.

Retinal and choroidal detachments occurred in the GSH series only after intracapsular extractions with wide iridectomy. In both series a higher incidence of retinal detachment occurred after vitreous loss.

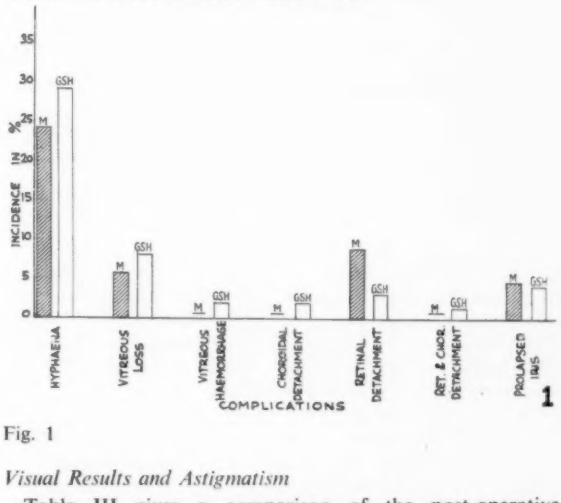

Fig. 1

Visual Results and Astigmatism

Table III gives a comparison of the post-operative astigmatism. It shows that there was a greater tendency towards astigmatism in the intracapsular extraction in both series. The GSH series reflects a larger degree of astigmatism with limbal section, without a preformed conjunctival flap than with limbal section with a flap.

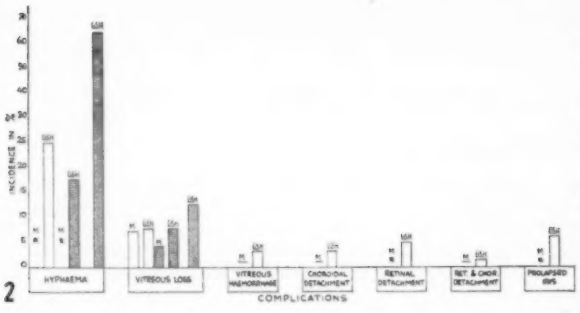

Fig. 2

TABLE III. ASTIGMATISM (DIOPTERS)

	Moorfields	*Groote Schuur*
Intracapsular	+2·52	+2·1
Extracapsular	+2·17	+1·5
Limbal Section without flap ..	*	+2·0
Limbal Section with flap	*	+1·5
Average	+2·34	+1·87

* Figures not available.

Table IV gives a comparison of the visual results. For the sake of comparison, these were assessed on the arbitrary scale which was used in the Moorfields series: 6/6 or better

TABLE IV. VISUAL RESULTS

	Moorfields	*Groote Schuur*
Intracapsular	3·33	3·0
Extracapsular	3·59	3·2
Following vitreous loss	5·29	5·0
Following retinal detachment ..	*	4·0
Average	3·31	3·1

* Figures not available

was rated as 1, 6/9 as 2, and so on to 6/60 as 7, counting fingers as 8, hand movements as 9, perception of light as 10, and a blind or lost eye as 11. Both series reflect slightly better visual results with intracapsular extractions. The results following vitreous loss were surprisingly good in both series; in the Moorfields series 42 cases were followed up, in the GSH series 8 cases.

DISCUSSION

A close and interesting correlation exists between the incidence of complications and the results in the GSH series of cases and the Moorfields series. It is of interest that the rather better visual results with intracapsular extraction is borne out in both series, as also the higher degree of astigmatism with this method. This presumably occurs because the corneal section is larger in intracapsular extraction. The GSH series also reflected a higher degree of astigmatism with limbal section without flap, as opposed to a limbal section with a preformed conjunctival flap.

In the Moorfields series 2/3rds of the cases were operated on without the use of sutures; in the GSH series sutures were used in all cases. Yet the visual results in the latter were, if anything, slightly better, and the post-operative astigmatism less. It was still less where conjunctivo-sclero-corneal sutures were used rather than corneo-scleral. Hence one must conclude that the use of sutures in cataract extractions does not increase the tendency to astigmatism—if anything it diminishes it.

Both series show a rather high incidence of post-operative hyphaemata, but the good average results obtained indicate that this is not a serious complication.

An interesting feature is the high incidence of hyphaema (64%) and vitreous loss (12½%) when the erisiphake method is used (Fig. 2). This is difficult to explain, but it has been suggested that it may be because maximum dilatation of the pupil is not always attained at operation, so that the lens is removed through a small pupil; perhaps also more trauma is produced when the erisiphake is introduced through a small pupil than when capsule forceps are used. However, this suggestion is widely disputed.

Finally, some light is thrown on the question of results following vitreous loss. This is always regarded as a very serious catastrophe, yet the cases with vitreous loss show an average post-operative visual result of 5·29 in the Moorfields series and 5·0 in the GSH series. This complication is perhaps therefore not quite so serious as it is at present thought to be.

Good visual results were also obtained in the 4 cases of post-operative retinal detachment. In both series this complication occurred more commonly with the intracapsular method and where vitreous had been lost.

SUMMARY

An analysis of a series of cataract extractions done at Groote Schuur Hospital, Cape Town, is compared with a similar series from Moorfields Hospital, London. Some observations arising from the Moorfields series are confirmed and additional observations arising from the Cape Town series are presented. These are:

1. In both series there is a good correlation between the incidence of complications and the results.

2. The use of sutures does not increase the tendency towards astigmatism—if anything it diminishes it.

3. Better visual results, albeit with increased astigmatism, were obtained with intracapsular extractions.

4. Limbal section without a preformed conjunctival flap produced a higher degree of astigmatism than limbal section with the use of a conjunctival flap.

5. In the GSH series a higher incidence of hyphaemata (64%) and vitreous loss (12½%) is recorded when the erisiphake method of extraction is used. It is suggested that inadequate pupillary dilatation during operation may play a part in this—but there is by no means general agreement on the point.

6. In both series it is shown that the post-operative visual results where vitreous loss occurred as a complication are fairly good.

I wish to thank Dr. R. L. H. Townsend, Head of the Department of Ophthalmology, Groote Schuur Hospital, for his constant encouragement and advice. I am indebted also to Dr. N. H. G. Cloete, Medical Superintendent, and Prof. J. H. Louw, Professor of Surgery, for permission to publish.

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THE USE OF ANTIBIOTICS IN FISH PRESERVATION

CECIL VON BONDE, M.A., PH.D., F.R.S.S.AF.

Fisheries Development Corporation of South Africa

The recent news that the Canadian Department of National Health and Welfare has announced its approval of the use of aureomycin for the preservation of fish should be welcomed by the world's fishing industry.

The problem of preserving a highly perishable food commodity like fish has been exercising the attention of fishery technologists for many years. Immediately after fish are taken from their natural environment, fresh-water or sea-water, bacterial invasion starts and the principal areas of infection are the intestinal tract, the gills and the slime of the skin, the end-result being a sour or putrid odour. This decomposition proceeds apace unless something is done to inhibit the bacteria and either destroy them or render them harmless.

Before a fish dies a certain amount of energy is expended in the death struggle and this has the effect of altering the chemical balance of the flesh or muscles. If food technologists were able to arrest the actions of enzymes and bacteria it might be possible to keep fish fresh for an indefinite time. Efforts to this end are made in the various methods employed in fish preservation, such as freezing, smoking, salting and canning, with varying results. Unfortunately, all bacteria are not accommodating enough to assist the technologists in attaining their goal. There are psycrophilic (literally, cold-loving) bacteria which can resist low temperatures; halophilic (salt-loving) bacteria which withstand the preserving action of salt; and thermophilic (heat-loving) bacteria which can tolerate high temperatures.

Although modern methods of freezing, smoking, salting and canning gave the fishing industry methods of preservation for limited periods, the inherent fish flavour is lost after a time. In freezing, the product loses water and the tissues undergo a change which eventually renders the fish unfit for human consumption. An exudation of fat on the surface of the fish, followed by oxidation, gives rise to what is known in the trade as 'rusting', the flesh taking on a rusty colour and becoming rancid. As these recognized methods of fish preservation did not achieve their ideal, technologists had to exercise their ingenuity in other directions in order to combat the agents of decomposition as soon as possible after the fish was caught and find the ideal method of sterilization.

Sterilization by radiation is still being studied experimentally and good results have been achieved, but the cost at the moment seems prohibitive.

Bacterial spoilage plays a far greater role in fish stored at ordinary refrigerator temperatures than it does in meats produced by warm-blooded animals, and the reason probably lies in the fact that fish are normally contaminated by psycrophilic bacteria. It has been established that at about 0°C the psycrophilic organisms have a very high growth coefficient (Q_{10}) and that the flesh of fresh fish spoils about twice as rapidly at 3°C as it does at −1°C.[1]

Experiments aimed at arriving at an ideal bacteriostatic agent have been conducted during the last 30 years. In 1928 Raj[2] advocated the use of sodium hypochlorite for the preservation of fish in tropical climates and found that fish so preserved was free from taint. It is a powerful preventative and sterilizer, but it is obsolutely safe since the salt is converted into sodium chloride during its action on organic matter[3]. Raj[2] described this preservative as the one likely to revolutionize the fresh-fish trade and curing yards in Madras. In 1938 Tarr[4] initiated the use of sodium nitrate as an inhibitor of spoilage of fresh fish, but although this chemical is still extensively used, it is not an ideal preservative.

ANTIBIOTICS

At the end of World War II. when penicillin became available, Tarr and his co-workers tried this antibiotic in experiments on bacterial spoilage in fish, but it was found to be practically valueless. He found that streptomycin and the sulpha drugs, e.g. sulphathiazole and sulphanilamide, were also failures. Early in 1950 Tarr investigated 15 antibiotics but was forced to discard 12 as useless and he concentrated on the remaining 3—chloromycetin, chlortetracycline and oxytetracycline—showing that they were effective for the preservation of both fish and beef. He proved that aureomycin (chlortetracycline—CTC) was the most effective.[5] These experiments were conducted at the Pacific Fisheries Experimental Station in Vancouver, B.C., of which Dr. Tarr is the Director.

Tarr and his co-workers concentrated on the best way to apply the antibiotic to fresh fish and solved the problem by mixing a small quantity (1-4 parts per million) of CTC hydrochloride in the water used with preparing flake-ice for the storage of fresh fish. At the meeting of the American Chemical Society in 1953 they stated: 'The results show that all the ices which contain small amounts of this antibiotic effected an extremely marked improvement in the keeping quality of the fish.'

The development of the broad-spectrum antibiotics which operate against a wide range of bacteria, has opened up new possibilities in the control of spoilage of foods due to bacterial action.

Aureomycin is the trademark of the American Cyanamid Company for the antibiotic chlortetracycline. This company has recently developed Acronize BI, a new CTC product which can be evenly distributed in block ice as a highly effective antibacterial agent. Acronize BI contains about 16½% CTC plus other ingredients which are all edible. As a general rule, when water containing pure CTC freezes, the water freezes first and a concentrated mass of CTC remains in the centre of the ice block. Acronize BI, combining the antibiotic with a metal salt and a protective colloid, combats this and forms a fixed gelatinous network throughout the ice. Since the primary function of Acronize BI is bacteriostatic, it cannot be used in highly contaminated fish in which bacterial spoilage has already begun, and therefore its use is restricted to the preservation of freshly caught fish.

As a rule, 5 ppm. CTC is used in ice and the following table (taken from a pamphlet *Acronize BI* issued by the American Cyanamid Company) shows its effectiveness in maintaining the freshness of halibut:

Storage Time after Capture (days in ice)	*Chlortetracycline in Ice used on Boat (ppm.)*	*Microorganisms $\times 10^6$ per g.*	*Organoleptic Observations*
13	0	23·2	Strong odour
	5	0·12	No offensive odour
16	0	84·8	Strong odour
	5	0·14	No offensive odour
20	0	568	Putrid
	5	3·42	Slight odour
22	0	886	Putrid
	5	54·6	Medium odour
26	0	1000	Putrid
	5	132	Putrid

Acronize FD has been developed for use in dips or for keeping fish in refrigerated sea-water, brine, etc.

In addition to experiments conducted in Canada and the United States, research in Bermuda into the use of fish dips containing Acronize has also produced satisfactory results. The dips varied in concentration from 1 to 5 g. per 10 l. of water and the dipping lasted for 15 minutes. After that the fish were stored in refrigerators at 34-38° F. Denmark (see below) has also proved the effectiveness of antibiotics.

Tarr[4] has shown that the destruction of CTC by heating is quite rapid.

At the meeting of Fish Processing Technologists held in Rotterdam in June 1956, 9 papers on the use of aureomycin in ice as a bacteriostatic agent for fish preservation were read and attention was focussed on the public-health aspects of the use of antibiotics in food. It was pointed out that, although its use was permitted for poultry in the United States, no other country at that time had sanctioned its use in any form for the preservation of food. Tarr stated that the use of low concentrations of aureomycin (chlortetracycline) were not dangerous to man, since 1 g. of CTC daily could be tolerated with impunity. In Canada sodium nitrite of which the

nges tion of 1 g. might prove fatal, has been permitted as a preservative since 1949.

In Denmark, experiments conducted by the Technological Laboratory of the Danish Ministry of Fisheries have proved that the antibiotics are rapidly destroyed by cooking and research was conducted into the use of antibiotics in the fishing industry in 3 ways.

1. As dip treatment whereby the fish are dipped into water containing an antibiotic.
2. As ice additives whereby water containing an antibiotic is frozen into ice to be used as a preservative on trawlers.
3. As spray treatment whereby the water containing an antibiotic is sprayed onto the fish.

The Torry Research Station near Aberdeen has recently also conducted experiments on a Hull trawler carrying ice containing aureomycin after a 17-day trip to the Iceland fishing grounds. The fish was landed in Hull in an excellent condition, but as the Food and Drugs Act would not permit of the sale of the catch, none was sold for human consumption, although the trade reaction to the fish displayed was very favourable. Mr. Class, President of the Hull Fish Merchants' Protection Association, declared: 'On the evidence of the samples landed in Hull, the experiment shows great promise and it is certainly well worth pursuing. The fish which had been treated with aureomycin were, in my opinion, distinctly superior in appearance to those not so treated and I am quite prepared to accept a scientist's statement that the flavour would be superior also.'

RESISTANT STRAINS

It is obvious that the public-health aspect of the use of antibiotics is one of paramount importance and in a paper read at the Rotterdam meeting on *Public health aspects of the use of antibiotics in foods*, Dr. C. Engel of the Central Institute for Nutrition Research, Utrecht, Holland, expressed the view: 'that sensitization of future patients and the induction of resistance in strains of bacteria are important problems which must be carefully considered before permission is granted to use antibiotics for keeping food in a fresh condition . . . . The best answer would be the use of antibiotics which are not applied in medical practice and do not give rise to cross-resistance in antibiotics in the human body.'[6]

Although Canada has now permitted the use of CTC for fish preservation, the US Food and Drug Administration is still studying the subject. In the US the use of these protective factors for poultry preservation was originally limited to CTC, but late in 1956 the Administration permitted the use of oxytetracycline as well. There is every reason to anticipate that, as research advances, the use of antibiotics for fish preservation in the US will also be allowed. It has, however, been stressed that the use of antibiotics cannot make bad foods good. It can only delay the spoilage of good food at a very low cost. This in itself may prove to be one of the greatest nutritional advances in modern food technology and the South African fishing industry should investigate the potentialities under local conditions. More intensive research is indicated to prolong the keeping qualities of the products still further.

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41st SOUTH AFRICAN MEDICAL CONGRESS, DURBAN
CONGRESS NEWS LETTER

This letter is to remind you that the next Scientific Meeting and Congress of the Medical Association of South Africa will be held in Durban from 16 to 21 September 1957, which is in about *4 months time*.

At the Inaugural Ceremony of the College of Physicians and Surgeons of South Africa, held in Johannesburg last August, the Honourable the Minister of Health said in his address that by the establishment of this postgraduate College it was evident that in Medicine at least, South Africa had grown up. This remark is more than confirmed by the arrangements being made for the forthcoming Congress to be held in Durban in September.

This Congress will be outstanding for a number of reasons. One of the more important features will be the Scientific Exhibition. This Exhibition includes a continuous scientific and research film-show on a wide variety of medical subjects and recent offers include a 16 mm. colour and sound film entitled *Stress and the Adaptation Syndrome*. This film has been prepared under the personal supervision of Prof. Hans Selye of Montreal and is a documentary summary of his far-reaching researches.

The comprehensive Scientific Programme of this Congress is attracting great interest overseas and a number of world authorities have accepted the invitation of the Local Organizing Committee to attend and take an active part in its Scientific Proceedings.

DISTINGUISHED GUESTS

The following visitors have signified their intention of attending Congress in September:

Sir Russell Brain, President of the Royal College of Physicians of London.

Sir Harry Platt, President of the Royal College of Surgeons, of England.

Prof. E. L. Bortz, Department of Medicine, University of Pennsylvania, U.S.A.

Prof. Alexander Brunschwig, Cornell University College of Medicine, New York.

Dr. R. Bryce-Smith, Nuffield Department of Anaesthesia, Oxford, England.

Dr. H. Churchill-Davidson, Anaesthetics Department, St. Thomas's Hospital, London.

Dr. J. H. Cyriax, Physician to the Department of Physical Medicine, St. Thomas's Hospital, London.

Dr. D. M. T. Gairdner, Consultant Paediatrician, Addenbrooke's Hospital, Cambridge, England.

Dr. Michael Gelfand, O.B.E., Physician, General Hospital, Salisbury, S. Rhodesia.

Mr. William Gissane, Surgeon to the Birmingham Accident Hospital, England.

Prof. T. Pomfret Kilner, C.B.E., Nuffield Department of Plastic Surgery, Oxford, England.

Prof. V. Kinross-Wright, Department of Psychiatry, Baylor University, Houston, Texas.

Mr. Charles Marks, Surgeon, General Hospital, Salisbury, S. Rhodesia.

Prof. Alan Moncrieff, C.B.E., Director of the Institute of Child Health, University of London.

Mr. A. Killey Monro, Lecturer in Surgery to the Postgraduate Hospital, Hammersmith, London.

Dr. J. S. Richardson, M.V.O., Physician, St. Thomas's Hospital, London.

Prof. Paul Wilflingseder, Department of Surgery, University of Innsbrück, Austria.

Mr. A. J. Wrigley, Obstetric Surgeon, St. Thomas's Hospital, London.

PLENARY SESSIONS

The subjects chosen for the Plenary Sessions are of the greatest interest to everyone today. The subjects and speakers will be as follows:

1. '*Cerebral Vascular Disease and the Problem of Aging*.'
   (*a*) Sir Russell Brain, President of the Royal College of Physicians of London.
   (*b*) Dr. M. M. Suzman, Johannesburg.
   (*c*) Dr. F. H. Kooy, Cape Town.
   (*d*) Mr. Keith L. Allen, Johannesburg.
   (*e*) Prof. E. L. Bortz, Philadelphia.
2. '*The Parasitic Diseases of man in Africa*.'
   (*a*) Dr. Michael Gelfand, O.B.E., Salisbury, S. Rhodesia.
   (*b*) Mr. Charles Marks, Salisbury, S. Rhodesia.
   (*c*) Dr. R. Elsdon-Dew, Durban.

3. '*The Surgery of Repair.*'
   (*a*) Sir Harry Platt, President of the Royal College of Surgeons of England.
   (*b*) Mr. William Gissane, Birmingham, England.
   (*c*) Prof. T. Pomfret Kilner, C.B.E., Oxford, England.
4. '*Recent Advances in Child Care.*'
   (*a*) Prof. Alan Moncrieff, C.B.E., London.
   (*b*) Dr. D. M. T. Gairdner, Cambridge, England.
   (*c*) Dr. H. L. Wallace, Durban.

SCIENTIFIC SECTIONAL MEETINGS

In addition to these Plenary Sessions there will be numerous Scientific Sectional Meetings in all the recognized specialities in both Medicine and Surgery, at which advanced and original work will be presented for discussion and review.

It would be premature to single out for comment any of the excellent papers so far offered, but it is anticipated that '*New Horizons in Chemotherapy*' by Prof. V. Kinross-Wright of the Department of Psychiatry, Baylor University, Houston, Texas, USA, will be more than timely. '*Recent Advances in Aviation Medicine*' and '*Medical Aspects of Atomic Warfare*', which will be presented by Senior Executive and Medical Officers of the Union Defence Force, with hitherto unpublished colour films, are combined Sectional Meetings which are certain to attract attention.

THE LIGHTER SIDE OF CONGRESS

The Ladies Auxiliary Committee under the able Chairmanship of Mrs. H. Grant Whyte is doing everything possible to provide a varied social programme and to ensure that everyone will be able to relax and enjoy their stay in Durban.

Social Functions

Monday, 16 September, 8.30 p.m. Opening Ceremony (evening dress and academic dress).
Tuesday, 17 September, 8.30 p.m. Congress Banquet.
Wednesday, 18 September, 6.30 p.m. Civic Reception.
Thursday, 19 September, afternoon, Campbell-Watt Trophy (Golf), and Casewell-Struthers Trophy (Bowls).
Friday, 20 September, 8.30 p.m. Congress Ball (evening dress).

Entertainment

The Chairman of the Clairwood Turf Club has kindly offered Honorary Membership of the Club to the Members of the Association for their Meetings to be held on Saturday 14 September and Saturday 21 September. The distinguished visitors will be the guests of the Stewards.

The Durban Club has extended Honorary Membership to gentlemen of the Association, and the facilities of the Ladies' Dining Room.

The Jewish Club has offered Honorary Membership to Members of the Association and their ladies.

Facilities have also been offered by the Durban Country Club, the Royal Natal Yacht Club and the Kloof Country Club.

Ladies' Programme

A programme of entertainments and excursions for visiting ladies has been prepared by the Ladies Auxiliary Committee and includes excursion to places of special interest, a Mannequin Parade, lectures on interior decorating and cooking, a Symphony Concert, and a Variety Show. A Tennis Tournament and a Bridge Drive have also been arranged.

The Banquet

On Tuesday evening, 17 September, a Banquet for Medical Graduates will be held in the City Hall, Durban, at which His Excellency The Governor-General has been pleased to signify his intention to be present. This function will give Members of the Association an opportunity of hearing and meeting informally our distinguished overseas visitors. Special arrangements will be made to ensure that fellow alumni, Members of Groups and friends may sit together and have the opportunity of renewing acquaintanceships.

The Ball

The Congress Ball will be held on Friday evening, 20 September, at 8.30 p.m. in the City Hall, Durban. Special arrangements are being made to ensure that this function will be the unique highlight of the social programme of the 1957 Medical Congress.

Sea Trips

For those of a more adventurous temperament the Port Authorities have offered to provide, each evening during Congress, ocean-going tugs in order to give Members of the Association an opportunity of putting in their 'sea-time'.

Special Date Stamp

The various Government and Local Authorities have combined in an all-out effort to ensure that a visit to Durban during Congress Week will be a most enjoyable experience and a lasting memory. It may be of interest to philatelists that the Postmaster General has approved for the use of the Medical Congress, a special date stamp from 16 to 21 September 1957.

IMPORTANT

1. Members wishing to attend Congress, and who have not so far indicated their intention to do so, should complete and return their Intention Card immediately.

2. Members wishing to read papers are reminded that a typed synopsis of their paper, not exceeding 500 words, must be in the hands of the Honorary Medical Secretaries, not later than 18 June 1957, and a typed copy in duplicate of the complete paper not later than 18 July 1957.

3. Intending visitors must book accommodation, if they have not already done so, immediately. Accommodation is still available in Durban.

53 Medical Centre,
Field Street,
Durban.
May 1957.

Hon. Organizing Secretaries
Dr. B. Crowhurst Archer
Dr. S. Disler
Hon. Medical Secretaries
Dr. J. Kelman Drummond
Dr. A. J. Wilmot.
Telegrams 'Medcongres'
Telephone 6-8415
After hours 5-6131

THE MEDICAL ASSOCIATION OF SOUTH AFRICA

MINUTES OF THE MEETING OF FEDERAL COUNCIL HELD IN JOHANNESBURG ON 27, 28 AND 29 MARCH 1957

Following are the Minutes of a Meeting of the Federal Council of the Medical Association of South Africa, held at Medical House, 5 Esselen Street, Johannesburg, on 27, 28 and 29 March 1957:

Present:

Ex Officio: Dr. J. S. du Toit (President), Dr. J. H. Harvey Pirie (Immediate Past Chairman), Mr. J. D. Joubert (Honorary Treasurer)

Border Branch: Dr. L. L. Alexander, Dr. R. Schaffer.
Cape Eastern Branch: Dr. E. M. Britten.
Cape Midlands Branch: Dr. L. E. Lane, Dr. M. A. Robertson.
Cape Western Branch: Mr. J. A. Currie, Dr. A. I. Goldberg, Dr. A. Landau, Dr. J. R. E. Lee, Mr. T. B. McMurray, Mr. J. A. S. Marr, Dr. H. G. Owen-Smith, Dr. F. W. F. Purcell, Dr. A. W. S. Sichel (Chairman of Council).
East Rand Branch: Dr. E. Meltzer, Dr. M. Segal, Dr. E. W. Turton.

Griqualand West Branch: Dr. J. P. Collins.
Natal Coastal Branch: Dr. A. Broomberg, Dr. E. W. S. Deale, Dr. S. Disler, Dr. H. Grant-Whyte, Dr. N. A. Rossiter, Dr. A. B. Taylor.
Natal Inland Branch: Mr. B. A. Armitage, Dr. N. M. Thompson.
Northern Transvaal Branch: Mr. J. G. A. du Toit, Dr. B. Epstein, Dr. J. H. Struthers (Vice-Chairman), Dr. J. H. Sypkens, Dr. F. Ziady.
O.F.S. and Basutoland Branch: Dr. D. Serfontein, Dr. R. Theron, Dr. G. F. C. Troskie.
Southern Transvaal Branch: Dr. C. Adler, Dr. A. L. Agranat, Mr. G. T. du Toit, Dr. J. Gluckman, Dr. S. C. Heymann, Mr. C. T. Moller, Dr. T. Radloff, Dr. Lewis S. Robertson, Dr. T. Schneider, Dr. M. Shapiro, Dr. L. O. Vercueil, Mr. J. Wolfowitz.
South-West Africa Branch: Dr. H. C. Paradisgarten.
Vaal River Branch: Dr. W. Chapman.
In Attendance: Dr. A. H. Tonkin (Secretary), Dr. L. M. Marchand (Associate Secretary).
Observers: Dr. T. Shadick Higgins (Editor), Dr. P. D. Combrink (Assistant Secretary, Transvaal).

WEDNESDAY, 27 MARCH

The meeting opened at 9.40 a.m., and the Chairman, Dr. A. W. S. Sichel, welcomed the members.

1. *Notice Convening the Meeting*, published in the *Journal* of 9 February 1957, was taken as read.

2. *Proxies and Apologies:* The Chairman called for Proxies, and these were read as follows: Mr. Currie to act for Drs. Impey, Fehrsen and J. P. de Villiers; Dr. Meltzer to act for Dr. Ochse; Mr. Moller to act for Dr. Peskin; Dr. Struthers to act for Dr. Waks; Dr. Britten to act for Dr. Solomon.

Apologies were noted from Dr. Black and Dr. Peskin, both of whom were ill. Council agreed that messages of sympathy be sent to both on behalf of Council.

3. *Introduction of New Members:* Dr. C. Adler introduced Mr. C. T. Moller.

4. *Minutes* of the Meeting held in Cape Town on 3, 4 and 5 October 1956, were *Confirmed and Signed.*

Matters Arising out of the Minutes:

5. *Expulsion from the Association—Amendment of Article 9*: The Secretary gave a resumé of the position and drew attention to a legal opinion which was contained in the Annexures to the Agenda. He explained that if Federal Council approved the suggested amendment of Article 9, it would have to go to an Extraordinary General Meeting of the Association for adoption. He stated also that it would be necessary for a certain strict procedure to be laid down under the Article. He outlined the procedure which had been drafted and which was at present with the lawyers in order that it might be put into correct legal form.

The Secretary said that the Executive Committee had considered this matter and had agreed to recommend to Council: (1) that Article 9 of the Association's Constitution be amended in accordance with the legal advice contained in the Annexures; (2) that the procedure outlined by the Secretary in his memorandum be endorsed and that after it has been put into legal form it be submitted to the Executive Committee for adoption on behalf of Council.

The recommendation of the Executive Committee was proposed by Dr. J. S. du Toit, seconded by Dr. Schaffer and *Carried Nem. Con.*

After discussion it was proposed by Dr. Shapiro, seconded by Mr. Wolfowitz and *Resolved*, 'That if the Branch or Divisional Ethical Committee recommends that the member be expelled, the member shall be entitled to submit a statement in his defence, either in writing or in person, to the Federal Council'.

It was further proposed by Dr. Lewis S. Robertson, seconded by Dr. Agranat and *Resolved*, 'That it be permissive for a Division to delegate the holding of an enquiry to a Branch'.

The Chairman stated that the matter would now be referred back to the Association's lawyers in order that Article 9 in its final amended form, together with the rules for procedure, might be drawn up in accordance with the wishes of Federal Council. *Noted.*

6. *Visit of Dr. T. C. Routley:* The Secretary reported that the question of a visit by Dr. Routley to South Africa had been discussed by the Council of the World Medical Association at its meeting in Havana. The Council was willing that Dr. Routley should make the visit, but owing to financial difficulty it was not clear yet whether the World Medical Association would be able to meet the cost. He mentioned that Dr. Routley had indicated in a letter that he would be very willing to attend the Congress in Durban.

Dr. Grant-Whyte said that the Congress Committee was anxious that Dr. Routley should be able to make the journey, and the Committee would go into ways and means of financing the project if the World Medical Association was unable to do so itself. The Secretary stated that he would take up the matter with the Organizing Committee at the close of the meeting. *Noted.*

7. *World Medical Association Assembly, Havana*, 1956: The Chairman stated that he had received a letter and report from Dr. Emilia Krause who had been the Association's representative at the World Medical Association General Assembly in Havana, together with a photograph taken at the meeting. Council *Agreed* that these be circulated for general information.

8. *Registration of Specialists—Recognition of Special Departments in Approved Hospitals:* A letter was submitted from the S.A. Medical and Dental Council, in which it was indicated that the Council had no intention of changing the rules at this stage.

Dr. Shapiro indicated that the matter was not yet closed so far as the Medical Council was concerned, as it had been referred back to the Specialists Committee for further consideration.

After discussion it was proposed by Mr. McMurray, seconded by Dr. Adler and *Resolved Nem. Con.*, 'That Federal Council requests the S.A. Medical and Dental Council to inform the Federal Council as to the specific requirements necessary for a hospital to be approved for specialist training by the S.A. Medical and Dental Council'.

9. *Ophthalmologists and Optometrists:* Reports and various items of correspondence were submitted, and the Chairman reported that the Executive Committee had agreed to recommend to Council that the whole matter be noted.

It was proposed by Mr. Armitage, seconded by Dr. Lewis S. Robertson and *Resolved* that the Executive Committee's recommendation be accepted.

10. *British Commonwealth Medical Conference*, 1957: The Secretary reported that the British Medical Association had found it necessary to postpone the Conference which had been planned for 1957, owing to financial difficulties. It had been suggested that the Conference be held in 1958 or 1959. *Noted.*

11. *Legal Defence:* Members were referred to a Report and a letter from the Medical Defence Union, and it was stated that the Executive Committee had agreed to recommend to Council that the Medical Defence Union be informed that the Medical Association of South Africa has no intention at this stage of extending its scope in regard to legal defence by concluding further agreements.

After short discussion it was proposed by Dr. Struthers, seconded by Dr. Broomberg and *Resolved* that the Executive Committee's recommendation be approved.

Dr. Disler pointed out that whereas formerly full-time employees in the service of Provincial Administrations had been covered in so far as their actions within hospitals were concerned, they were now no longer so covered. He felt that this was very unsatisfactory from the point of view of members of the Association and that steps should be taken to deal with this situation.

The Secretary stated that in the Cape Province the Director of Hospital Services Department had been in touch with him in regard to the personnel employed by that Service. As a result he was to communicate with all the Medical Superintendents to suggest that the medical practitioners on their staffs should seek private insurance cover.

It was proposed by Dr. Disler, seconded by Dr. Grant-Whyte and *Resolved*, 'That Federal Council take up the question of the legal protection of full-time personnel in the employ of the Provinces with the Co-ordinating Committee of the four Provinces'.

12. *Vaal River Branch:* The Secretary stated that the Vaal River Branch had been approved in principle at the last meeting of Council, subject to the Executive Committee's approval of its Constitution. The Constitution had subsequently been approved by the Executive Committee, and it was now for Federal Council to confirm that the Branch had come into being on 4 March 1957.

Approval was *Accorded with Acclamation.*

On behalf of the Council, the Chairman extended to Dr. Chapman congratulations and good wishes for the success of the new Branch.

AFFAIRS OF TRANSVAAL BRANCHES

13. *Enquiry into the Affairs of the Transvaal Branches* Dr. Sichel referred to the Report of the Committee of Enquiry which was contained in the Annexures, and stated that the Council was greatly indebted to Dr. Schaffer and Mr. McLeod who had undertaken the work so efficiently and at great sacrifice. He expressed thanks and appreciation to Dr. Schaffer and asked him if he would introduce the Report.

Dr. Schaffer thanked Dr. Sichel for his remarks. He drew attention to a mistake which had occurred in setting out the Report, which he asked members to correct.

Dr. Schaffer stressed the place which Contract Practice occupied in the economics of the practice of medicine as a whole, and said that he felt that a complete survey of the whole matter should be undertaken. He went on to deal with other aspects of the Report and paid tribute to the members who served on Committees and did a considerable amount of work for the Association.

Dr. Schaffer's Report was *received with Acclamation*, and the Chairman then stated that the Report was open for discussion.

Many members took part in the considerable discussion which followed.

Council adjourned for lunch at 1 p.m. and reassembled at 2.15 p.m.

Discussion continued, and it was proposed by Dr. Shapiro, seconded by Dr. Gluckman, 'That the duties of the Assistant Secretary in the Transvaal shall include that of acting as Secretary of the Regional Committee on Contract Practice in the Transvaal and of the Committee on the Economics of Medical Practice'.

Further discussion followed in regard to the duties of the Assistant Secretary, and eventually the above resolution was withdrawn in favour of a further resolution proposed by Dr. Shapiro and seconded by Dr. Turton, 'That the duties of the Assistant Secretary in the Transvaal shall include: (1) such duties as are delegated to him by the Secretary; (2) the affairs of the Augmented Executive Committee in the Transvaal; (3) the affairs of the Parliamentary Committee; (4) the affairs of the Central Committee for Contract Practice; (5) the affairs of the Workmen's Compensation Act Committee; (6) the affairs of the Committee on the Economics of Medical Practice. (7) That where Branches must meet in order to discuss Contract Practice matters in terms of Minute 25 (*b*) of April 1956, the Assistant Secretary in the Transvaal shall act as Convener and Secretary of the Joint Contract Practice Committees of the Branches concerned'. On being put to the vote, this resolution was *Carried*.

Further discussion followed regarding the difficulties connected with negotiation in Contract Practice matters. Various speakers gave instances of this, particularly in cases where the Contract Practice affairs overlapped the areas of more than one Branch. Dr. Sichel pointed out that it was competent for Branches to hand over such difficult matters to the Central Committee for Contract Practice, but that if they did this they must leave further negotiation to the Central Committee only. It was then proposed by Dr. Sichel, seconded by Dr. Shapiro, 'That if a Branch (or Branches) in negotiation with regard to Contract Practice matters in its area is confronted with an impasse, it would be competent for that Branch to request the Central Committee for Contract Practice, through its Executive Committee, to take over such negotiations'. After short discussion, this resolution was put to the vote and *Carried*.

Discussion then took place regarding the domicile of the Assistant Secretary, and eventually it was proposed by Dr. Shapiro seconded by Dr. Agranat, 'That Minute 112 of October 1956, be rescinded where it states that the Assistant Secretary should be domiciled in Johannesburg in the first instance, and that it be decided now that he should have his office in Pretoria'. On being put to the vote, this was *Carried Nem. Con.*

There being no further discussion on the Report of the Committee of Enquiry, it was proposed by Dr. Shapiro that the Report be noted and that the authors be heartily thanked for their work. This was *Carried with Acclamation.*

Council *Agreed* that the Secretary should consider any items in the Report which should be referred to the Executive Committee and should raise them at a later date.

Before proceeding to the next item, the Acting Chairman stated that there were two matters which should be clarified. The first concerned the supervision of the Assistant Secretary in the Transvaal. It should be clearly understood that the Assistant Secretary was under the control and supervision of the Head Office and Journal Committee, but that it was competent for the Head Office and Journal Committee to delegate its powers of supervision to some person or persons in the Transvaal. Council *Agreed* accordingly.

The other matter referred to by the Acting Chairman concerned the calling together of Branches who might wish to discuss Contract Practice matters which affected more than one Branch. He felt that if a Branch wished to meet other Branch Contract Practice Committees, it should refer the matter to the Assistant Secretary who would then act both as Convener and Secretary of the meeting. Council *Agreed.*

MINES BENEFIT SOCIETY SERVICES

14. *Mines Benefit Society Services:* The Secretary read two letters which had not been included in the Annexures. One was from the Southern Transvaal Branch dated 19 March, and the other was from the Honorary Secretary of the Urological Group of the Southern Transvaal Branch in which it was stated that the urological service to the Mines Benefit Society should be on the basis of an open panel at Medical Aid Society rates, failing which the service should be supplied on an open panel basis on a tariff to be agreed upon.

Discussion followed in connection with the whole question of the Mines Benefit Society's service, and it was proposed by Mr. Wolfowitz, seconded by Mr. McMurray, 'That in view of the Mines Benefit Society not being prepared to accept the one-in-10,000 rule in regard to urological appointments, and the failure of the Society to produce information which the Federal Council considers as being "extenuating circumstances", the urological service to the Mines Benefit Society shall be on the basis of an open panel'. After further discussion the proposer and seconder agreed to withdraw this resolution.

15. *Leipoldt Memorial Medal for* 1955: The Secretary explained that Dr. L. Solomon, of Upington, had not been able to attend the Adjourned Annual General Meeting in Cape Town last October in order to receive the Leipoldt Memorial Medal for 1955 which had been awarded to him. As Dr. Solomon was now temporarily resident in Johannesburg, he had been asked to come to this meeting of Council to receive the Medal.

The President, Dr. J. S. du Toit, then presented the Medal to Dr. Solomon amid *Acclammation.*

Council adjourned for dinner at 5.40 p.m. and resumed at 8.15 p.m.

16. *Mines Benefit Society Services* (continued): The debate on this subject continued after dinner, and it was proposed by Mr. Wolfowitz, seconded by Dr. Shapiro, 'That the matter of the urological services to the Mines Benefit Society be referred back to the Southern Transvaal Branch to be negotiated further on the basis of the policy of the Association in regard to Benefit Society appointments'. This was put to the vote without further debate and was *Carried Nem. Con.*

Following further discussion, it was proposed by Dr. Shapiro, seconded by Dr. Adler, 'That it be recommended to the Southern Transvaal Branch that in so far as the Mines Benefit Society concerns a number of Branches, matters should be dealt with at the level of a "Liaison Committee".' Council generally *Agreed* and further *Agreed* that the 'Liaison Committee' should be composed of representatives of the Southern Transvaal, East Rand, O.F.S. and Basutoland and Vaal River Branches.

At the close of the discussion on this subject, Mr. Currie gave notice of motion, seconded by Dr. Purcell, as follows: 'That the Central Committee for Contract Practice or any other committee appointed *ad hoc* by the Federal Council, be empowered to negotiate with the Mines Benefit Society an entirely new basis of relationships with the Association.' *Noted.*

17. *Specialist Services to Benefit Societies* Members were referred to a notice of motion in the Annexures, referring to Minute 94 of the record of the last meeting of Council, reading: 'That in the opinion of Council a specialist accepting an appointment to a Benefit Society should undertake to do the work himself.' The notice of motion put forward by Mr. G. T. du Toit and seconded by Dr. Agranat was to the effect: '(1) That the motion be rescinded. (2) That in the opinion of Council a medical man accepting an appointment to a Benefit Society should accept full and reasonable responsibility for the work done, irrespective of the employment of assistants or partners.'

After discussion, Mr. J. G. A. du Toit stated that if the resolution to rescind the previous Minute was carried, he would pro-

pose an amendment to the second portion, to read: 'That in the opinion of Council a medical man accepting an appointment to a Benefit Society should do the consultative and major surgical work personally.' Dr. Ziady said that he would second such an amendment.

After further discussion, the motion to rescind was put to the vote and *Lost* by 10 votes to 24. The second portion of the resolution, and the amendment, thus fell away.

18. *Reasons for the Open Panel System:* Members were referred to a letter from the Mines Benefit Society, in which it was suggested that the reasons for the open panel system should be fully explained.

Dr. Shapiro pointed out that the system had been explained very fully at various meetings which had taken place.

The Acting Chairman suggested that the matter be left over until the Report of the Executive Committee on the best means of implementing the open panel system was discussed. Council *Agreed* accordingly.

19. *Liaison with Dental Association of S.A.:* The Secretary stated that at the last meeting of Council the question of an exchange of representatives attending the Federal Council meetings of the two Associations was left over for further consideration. The Executive Committee had agreed to recommend to Council that this matter be left to the Liaison Committee which had already been set up between the Medical and Dental Associations, and that representation at the Council meeting of one or other of the Associations only be undertaken when necessary and on the recommendation of the Liaison Committee.

Council *Agreed* to the recommendation of the Executive Committee.

20. *Appointment of Assistant Secretary (Transvaal):* A Report by the Secretary, concerning the appointment and initial work of the Assistant Secretary in the Transvaal, was submitted. Council *Noted* the Report.

21. *Rules regarding Registration of Specialities of Medical Practitioners and Dentists:* Council was reminded that this matter had first been referred to the Association by the S.A. Medical and Dental Council in July 1956. The proposed Ethical Rules had been sent to the Branches for consideration, and as the Council had ruled at that time that the replies of the Branches should be sent direct to the Medical Council it was not possible to formulate any concerted opinion. In the circumstances the Executive Committee had agreed to recommend to Council that the views of the Federal Council on the Rules for Specialists, based on the opinions of the Branches, be transmitted to the Medical Council without committing the Association to any expression of opinion in regard to the question of the statutory registration of specialists.

After discussion Council *Agreed to Accept* the recommendation of the Executive Committee.

22. *Telephone Consultations:* A letter from the S.A. Medical and Dental Council was submitted, in which it was stated that the Executive Committee of the Council 'is of the opinion that in general consultations by telephone should be discouraged. The Committee can, however, visualise circumstances under which such consultations would be proper and under which the right of a medical practitioner to make a charge therefor could not be disputed.'

Council *Agreed* that the letter from the Registrar be *Noted*.

23. *Circulars to Branches:* The Secretary stated that this matter had been raised by the Southern Transvaal Branch, and that the Executive Committee had agreed to recommend to Council that Branch Secretaries be invited to advise the Secretary if they required extra copies of circulars to Branches and, if so, how many copies would be needed for distribution to Branch Council members.

Council *Agreed* to the recommendation of the Executive Committee.

24. *Medical Women—Retiring Age and Employment in Permanent Posts:* The Secretary reminded Council that letters had been sent on behalf of Council to the Minister of Health and the Public Service Commission. The replies to these letters were contained in the Annexures. He stated that the Executive Committee had agreed to recommend to Council that the correspondence be noted and that the replies from the Minister and the Public Service Commission be sent to the S.A. Society of Medical Women.

Council *Agreed* to the recommendation of the Executive Committee.

25. *Johannesburg Society on Alcoholism:* The Secretary stated that this matter had not received attention at the last meeting of Council as it had not been considered urgent. He added that the Executive Committee had agreed to recommend to Council that the Southern Transvaal Branch appoint a representative to this body.

Council *Agreed* to the recommendation of the Executive Committee.

26. *Sub-Committee on Rehabilitation:* Mr. G. T. du Toit presented his Report and in addition spoke of rehabilitation schemes which were being put forward by the Minister of Labour.

Finally it was proposed by Mr. G. T. du Toit, seconded by Dr. Adler and *Resolved:* '(1) That the Medical Association recognizes with pleasure that the Minister of Labour has initiated a rehabilitation scheme for disabled work-seekers, more particularly those in sheltered employment. The Association is desirous that its members who have specialized knowledge in this field should be allowed to be of assistance in this development. The Association believes that this purpose can best be served by the appointment of a Technical Advisory Board on which such experts can serve. (2) That the Minister be asked to meet a deputation of the Association to discuss this proposal.'

After discussion Council *Agreed* that the deputation should consist of members of the Parliamentary Committee and that it should have power to co-opt such members of the Sub-Committee on Rehabilitation as it thought necessary.

27. *Sub-Committee to Advise Controller of Imports:* A Report was submitted, in which it was stated that 47 applications had been considered from importers, covering 73 products, of which 27 were not recommended. Four applications had been received from medical practitioners and one from a layman for the importation of medical supplies or equipment not obtainable through the ususal trade channels, all of which had been supported.

Council *Noted* the Report of the Sub-Committee.

28. *Sub-Committee on Medical Fees for Private Practice:* A Report was submitted, in which it was stated that the Sub-Committee had held no further meetings since the last meeting of Council; but in accordance with the decision of Council it had submitted the schedules of fees received from the Branches, and confirmed by Council, to the S.A. Medical and Dental Council. The Report also drew attention to a letter received from the Executive Committee of the Medical Council, drawing the attention of the profession to the desirability of advising patients of the cost of extensive investigations to be undertaken. It was stated that this letter had been published in the *Journal*, while a sub-leading article had been published at the same time.

After short discussion, Council *Agreed* that the Report be *Noted*.

29. *Sub-Committee for Liaison with Dental Association of S.A.:* The Convener stated that there was nothing further to report, other than the matter which had already been dealt with under Minute 19 above. *Noted*.

30. *Sub-Committee for Liaison with S.A. Nursing Association:* The Convener stated that there was nothing to report. *Noted*.

31. *Sub-Committee to Enquire into Medical Education and Internships:* Mr. McMurray submitted the Report of this Sub-Committee and referred to a further Report concerning the Training of Interns in Anaesthetics. He said that this latter matter was fraught with great difficulty and that the Sub-Committee did not think that the intern should be given one month's special training in anaesthesia.

Mr. Joubert stated that the work of the Report had been almost entirely due to the efforts of Mr. McMurray and that the Council owed him a debt of gratitude for all his work. The Council's thanks were accorded *with Acclamation*.

After discussion Council *Agreed* that all the Reports produced by the Sub-Committee be sent to the World Medical Association in connection with a conference on medical education which the World Medical Association was convening in Chicago in 1959. Council further *Agreed* that the latest Report should be sent to the S.A. Medical and Dental Council and that the Editor should be asked to publish the Report in the *Journal*.

Dr. Landau asked whether the Sub-Committee was to be discharged, but Council agreed that the Sub-Committee should remain in office.

32. *Sub-Committee on Groups within the Association:* A Report

by the Secretary was submitted, incorporating the views of four of the Groups within the Association. He stated that the question now arose as to whether the recommendations of the Sub-Committee were to be incorporated in the By-Laws.

Short discussion followed, but the Chairman stated that as the hour was late Council should agree to leave the matter over for further consideration. Council *Agreed.*

Council adjourned at 11 p.m.

THURSDAY, 28 MARCH

The meeting commenced at 9.10 a.m., Dr. Sichel being in the Chair.

33. *Dispensing by Doctors:* Dr. Vercueil submitted a Report on the activity of the Liaison Committee which had been set up with the S.A. Pharmaceutical Society. The Report contained a recommendation that the Joint Committee 'should be given continued status to proceed with investigation of the problem as it may affect the common interests of both professions, with a view to making a recommendation at a suitable date to the respective organisations for action by the best possible means to deal with this problem in all its aspects.' He moved accordingly, seconded by Dr. Grant-Whyte.

After discussion Council *Accepted* the resolution and *Agreed* that Drs. Turton, Vercueil, Agranat and Peskin be elected to the Committee with power to co-opt.

34. *Sub-Committee for Liaison with Pharmaceutical Society of South Africa:* Dr. Vercueil stated that other than the matters referred to in the previous Minute, there were no further discussions with the Pharmaceutical Society. *Noted.*

FINANCIAL STATEMENT

35. *Financial Statement:* The Honorary Treasurer, Mr. J. D. Joubert, presented his Report as follows:

'At the time of writing this Report, the audit for the year ended 31 December 1956, has bot been completed. It is probable that the audit will have ended by the time Council meets, although the final report may possibly not be ready for distribution.

'The gross revenue from Advertising in the *Journal* amounted to £34,927 as against £36,793 in 1955. This shows a decrease of £1,866. Members will recall that at the last meeting of the Council it was stated that "there has undoubtedly been a considerable drop in our advertising income." (Also, one issue less was published during 1956). This is due to the fact that while advertisers are spending the same amount on advertising, they are spreading their money over more journals. The expenditure on Printing and Blocks for the *Journal* amounted to £20,934, being an increase of £508 over the previous year. In 1956 the *Journal* contained 2,764 pages, whereas in 1955 it contained 2,860 pages, being a decrease of 96 pages. This is partly accounted for by the fact that only 52 issues of the *Journal* were printed in 1956 against 53 in 1955, and there was also a steep rise in the cost of paper during the year.

'Salaries and Allowances, Pension Contributions, Unemployment Benefit Fund Contributions and Pensions accounted for an increase of £1,906 over the previous year. A certain portion of this is due to Mr. Johns and his typist, as well as the employment of an additional stenographer and certain temporary staff employed at Head Office, together with normal increases.

'Postages and Telegrams cost £1,061, being a decrease of £46. Delegates' travelling expenses amounted to £3,014, being an increase of £298. Subscriptions from members and non-members amounted to £12,676, being an increase of £60.

'*The South African Journal of Laboratory and Clinical Medicine* showed a loss of £602.

'The Agencies in both Cape Town and Johannesburg have shown a profit, the exact amount of which is not yet known.

'The Medical Insurance Agency shows an income of £3,049. This is a decrease of £18 over the previous year.

'At the last meeting of the Council it was reported "that the debit balance at the end of the year will probably be in the neighbourhood of £2,500." The final account will show a deficit, but the exact amount will not be known until the audit is completed. It is likely, however, that this will amount to approximately £3,100. It will be recalled, however, that a grant of £500 was made to the Southern Transvaal Branch at the last meeting and that this was not taken into account when the Financial Report was given.

'*Financial Report of the Benevolent Fund:* It is with pleasure that I can report that the income of the Fund during 1956 amounted to £5,155. This is an increase of £1,394, but it must be borne in mind that during the previous year there had been a decrease in the income of £1,237. Of this amount £2,488 was received in interest on investments. Through the generosity of members and others, an amount of £273 was received "In Memoriam" by means of votive cards, while £366 was received for "Services Rendered". Donations and legacies amounted to £2,068. Special reference should be made to the efforts of Divisions and Branches. The Northern Division of the Natal Inland Branch contributed £30. The Potchefstroom Division of the Southern Transvaal Branch contributed £7 6s. 0d. The Pietersburg Division of the Northern Transvaal Branch sent a gift of £25 1s. 6d. The Southern Transvaal Branch Golfing Society donated £25. The Cape Western Branch collection box brought in £20 3s. 6d., while the Medical Wives' Association of the Cape Midlands Branch contributed £170 6s. 8d. Branch donations were: Griqualand West Branch £38; Southern Transvaal Branch £583; Natal Coastal Branch £240. An amount of £600 was received by way of legacies.

'During 1956 grants totalling £3,195 were paid to beneficiaries.

'It is calculated that the accumulated funds will amount to £43,925 as at 31 December 1956.

'On behalf of the Management Committee I would like to express great appreciation of the support which members have given to the Association's Benevolent Fund.'

ANNUAL SUBSCRIPTION

Mr. Joubert referred also to an item appearing in the Additional Annexures, under the Report of the Head Office and Journal Committee, which read as follows:

'*Annual Subscription:* The Committee considered this matter which was mentioned at the Federal Council meeting held in Vereeniging in April 1956, and instructed the Secretary to draw up a memorandum based on the discussion which had taken place and containing the Committee's recommendation. The memorandum is as follows:

"A year ago at Vereeniging the then Honorary Treasurer, Dr. J. S. du Toit, in presenting the Estimates for the year 1956, forecast that there would be a deficit of some £2,500. In the circumstances he suggested that the subscription rate should be raised by £1 1s. 0d. per annum for all members. It was pointed out that the original subscription payable to the Association when it was formed in 1927 was £1 8s. 6d. and that this had been raised by 2s. 6d. in 1945. Subsequently there was a further rise of 11s. on 1 January 1953, when it became £2 2s. 0d. The suggestion that the subscription be raised was deferred until the end of 1956 and it was decided that the Council would examine the position in the light of the outcome of the year's work. This outcome in the Financial Statement shows a deficit of approximately £2,930, of which, it is presumed, the £500 paid as a subsidy to the Southern Transvaal Branch would not be a recurring expense. Therefore the real deficit is as forecast a year ago, approximately £2,500.

"In 1955 the *Journal* Account showed a profit of approximately £3,800 which was transferred to the General Revenue and Expenditure Account where £2,500 was absorbed in order to balance the accounts of the Association and eventually show a profit of £1,300. In other words, the *Journal* subsidised the Association to the extent of £2,500. The effect of this subsidy was to reduce the amount which members should have paid to the Association by approximately 9s. 6d., in addition to the fact that they already receive a free copy of the *Journal* weekly by virtue of their membership and in accordance with Article 5.

"The Association should not be dependent on sources of income other than the members' subscriptions and the interest on investments, and the services which are supplied by the Association should be paid for by the members by means of their subscriptions. Any profit which are thus made by the *Journal* should not in effect be shared amongst members by the reduction of the subscription which they should pay, but should be used for the purposes of the *Journal* in production and improvement, and should there still be a profit it should be transferred to the Capital Account and not to the General Revenue and Expenditure Account. In this way it would guard against any deficits which might arise to the *Journal* from the loss of advertising revenue through internal or external disturbances which might well be coupled with rising paper and printing costs.

"In stating that the Association as such should depend on the members' subscriptions, it should be pointed out that the only saleable commodity which the Association has for members is the services of its officials and employees. As the members ask for service so it must be supplied. The services were expanded in 1946 and the subscription was raised by a small amount. In those days the demands were few. Increased services were met by the appointment of the Associate Secretary in 1951 and again the subscription was raised. Once more there have been demands for more service to members which entail not only the appointment of an additional official but the opening of an office in the Transvaal. The cost of this must be met and the only reasonable means of meeting it is by buying the service by means of an increased subscription.

"In addition to the services which members pay for by means of the salaries of officials and employees, other costs have risen in the Association's work. It is common knowledge that all ordinary commodities cost more and the expenses of conducting an office are high. Members have mentioned this frequently in arguments for increasing the fees in medical practice. Travelling costs have increased and have given rise to another argument for higher medical fees. In all these rising costs the Association has also suffered. In 1945 the delegates' travelling expenses were £832, while today they are over £3,000 per annum.

"In considering the question of an increased subscription, members must consider first whether the Association is providing them with a service. Is it taking care of their interests? From the financial standpoint in regard to Medical Aid Society fees the increases which have taken place during the last ten years have been such that the Association can claim to have served its members well in this regard alone.

"Many other instances can be cited if they are really necessary, but Federal Council members should be well aware of them, for often they have initiated them and taken part in their achievement. Not only have medical fees been raised in private as well as Medical Aid practice, but Workmen's Compensation fees have been raised, emoluments of Railway Medical Officers and District Surgeons have been increased and salaries generally have kept an upward trend, appointments have been made in general hospitals and negotiations have taken place with many organisations for the improvement of the conditions of service of medical men.

"The Association now needs the members to recognise their obligations in payment for services rendered and still to be rendered in the future.

"There is a further aspect of the financing of the Association which should be considered. In 1945 the amount of revenue derived from insurance commission was £425. In 1955 this income reached an amount of £3,067. When it was decided to set up the Medical Insurance Agency in 1950, the question arose as to whether it would be administered in the same way as the Medical Insurance Agency carried on by the British Medical Association, in which case the profits arising from the Insurance Agency work would be used for purposes of benevolence. At that time the Council agreed that the total revenue should be absorbed into the Revenue and Expenditure Account, so that the Benevolent Fund has benefited in no way through the administration of the Insurance Agency. Certain members have criticized this from time to time and have felt that beyond receiving a reasonable amount for administration purposes the profits should be paid to the Benevolent Fund so that the Association as such could not be accused of 'trading' in opposition to insurance agents whose living depends on the business they procure. If the administration costs of the Medical Insurance Agency were estimated at 20% of the revenue, it would mean that the General Revenue Account would be short of more than £2,000 which would then be transferred to the Benevolent Fund.

"These, then, are some matters which are brought to the attention of members for careful thought. If the Association is to fulfil its purpose properly it should not be handicapped by lack of funds. The only alternative to a raised subscription is to cut down the service which members have demanded, by means of drastic economics which must include retrenchment. Obviously the service must suffer if the people to provide that service are no longer employed. The Head Office and Journal Committee have given this matter considerable thought in the light of all the circumstances of present-day economic trends and, mindful of the part which the Association has played and must continue to play in the life and existence of the medical profession, it has agreed that the best interests of the members will be served by putting forward the following recommendation: '*Resolved to Recommend to Council* that as from 1 January, 1958, the amount of subscription payable to the Association be increased to £4 0s. 0d. per annum from the present figure of £2 2s. 0d." '

In conclusion Mr. Joubert referred to the economic difficulties which were facing Medical Associations all over the world, where it had been found necessary to raise subscriptions.

He thanked members for listening so patiently to his Report. *Acclamation.*

The Chairman pointed out that in view of the changes which had taken place in the whole economic structure of the world, he felt that it was time that the organisation of the Medical Association was overhauled.

It was proposed by Dr. Schaffer, seconded by Dr. Goldberg, that a committee be appointed to investigate all aspects and to make recommendations as to the future organisation of the Medical Association.

It was proposed by Dr. Shapiro, seconded by Mr. Wolfowitz, that Council go into committee. Council *Agreed.*

While in committee, Council adjourned for lunch from 1.5 p.m. to 2.20 p.m.

At 2.45 p.m. Council *Agreed* to go out of committee.

In regard to the proposal by the Head Office and Journal Committee that the annual subscription rate be raised, an amendment was proposed by Dr. Shapiro, seconded by Dr. Schneider, that consideration of the question of raising the capitation fee be deferred to the next meeting of Council.

A second amendment was proposed by Mr. Moller, seconded by Mr. McMurray, that the subscription be put up at the September meeting by an amount to be determined at that meeting.

After discussion the second amendment was put to the vote and was *Lost.*

The first amendment was then put to the vote and *Carried* by 27 votes to 18. It was also *Carried* as the substantive motion.

Council agreed that the proposal by Dr. Schaffer be discussed at a later stage of the meeting.

The Honorary Treasurer then moved the adoption of his Report, seconded by Dr. J. S. du Toit. This was *Carried with Acclamation.*

EXECUTIVE COMMITTEES' REPORT

36. *Report of the Executive Committee:* Dr. Sichel presented the Report of this Committee which had been included in the Annexures to the Agenda. He stated that there had been no meetings of the Executive Committee, but a considerable number of matters had been dealt with by correspondence. They were as follows:

37. *National Health Services Emergency Fund:* The Report stated: 'A letter was received from the Standard Bank of South Africa indicating that this fund had lain dormant since 9 August 1954, and that in accordance with the law the unclaimed balance would have to be paid to the Master of the Supreme Court unless the matter was given immediate attention. The Honorary Treasurer suggested that the balance standing to this account, namely £257 2s. 6d., be transferred to the Association's current account. The Executive Committee agreed.'

Council *Confirmed* the action of the Executive Committee.

38. *S.A.R. & H. Sick Fund—Specialists in Physical Medicine, Johannesburg:* The Report stated: 'An advertisement for these appointments was received on 24 September for publication in the *Journal* of 13 October. According to the usual procedure, the advertisement was referred to the Southern Transvaal Branch for approval. After some delay the Branch agreed to approve the appointments on a temporary basis for one year subject to the concurrence of the Executive Committee. The Executive Committee concurred.' *Noted.*

39. *Appointments in Military Hospitals:* The Report stated: 'This matter had been referred to the Parliamentary Committee for action. The Parliamentary Committee took such action as it considered necessary, and in view of the explanations which had been received, it recommended to the Executive Committee "that no further action should be taken towards interviewing the Minister of Defence." ' The Executive Committee agreed with the recommendation of the Parliamentary Committee.'

Council *Confirmed* the action of the Executive Committee.

40. *Post-operative Care in Medical Aid Society Cases:* The Report stated: 'The Secretary of the Ear, Nose and Throat

Group had written a letter stating, "The recent decision of Federal Council that surgeons are responsible for all post-operative care in Medical Aid cases amazes me as this is a completely new departure." He quoted the case which had led to this decision as being the development of an acute otitis media five days after the removal of tonsils and adenoids by a specialist. A general practitioner had been called in who had treated the otitis media for four days. Subsequently the Medical Aid Society had refused to pay the general practitioner's account, holding the specialist responsible for all post-operative care. It was pointed out by the Associate Secretary that the Central Committee for Contract Practice had not been given these details and had "dealt only with such care as normally followed an operation and which the specialist might ask the general practitioner to carry out." The Committee had recommended to Council accordingly and the resolution of Council had followed. The opinion of the Executive Committee coincided with the opinion originally expressed by the Central Committee for Contract Practice and it agreed that unexpected complications which may occur during convalescence should be dealt with by Medical Aid Societies as separate conditions. It was also felt that each case should be dealt with on its merits.' *Noted.*

The East Rand Branch had submitted a memorandum on this subject for consideration by Council. Council *Agreed* that a small committee be appointed to consider the memorandum, and that the committee consist of Dr. Segal as Convener with the two other Council members from the East Rand Branch, with power to co-opt.

41. *Date of Meeting of Council:* The Report stated: 'The Committee agreed that the next meeting of Council should be held on 27, 28 and 29 March, 1957.' *Noted.*

42. *Amendments to Constitution of S.A. Society of Medical Women:* The Report stated that the Executive Committee had agreed to the amendments to the Constitution of this Group as referred to it by Federal Council.

Council *Confirmed* the action of the Executive Committee.

43. *Amendments to Constitution of Orthopaedic Surgeons' Group:* The Report stated that the Executive Committee had agreed to the amendments to the Constitution of this Group as referred to it by Federal Council.

Council *Confirmed* the action of the Executive Committee.

44. *Amendments to Constitution of S.A. Society of Anaesthetists:* The Report stated that the Executive Committee had agreed to the amendments to the Constitution of this Group as referred to it by Federal Council.

Council *Confirmed* the action of the Executive Committee.

45. *Economics of Medical Practice:* The Report stated: 'When the members of the Sub-Committee on the Economics of Medical Practice tendered their resignation which was accepted by Federal Council, it was agreed "that this matter be referred to the Executive Committee of Federal Council who should receive all the reports of the Sub-Committee on the Economics of Medical Practice so that the Executive Committee could then deal with the matter as they thought best." The Chairman of Council sent a circular to members of the Executive Committee, suggesting that an *ad hoc* committee be formed in Cape Town to examine all the documents gathered by the former Sub-Committee and that this *ad hoc* committee consist of the President, the Chairman of Council, the Honorary Treasurer, Dr. A. Landau, Mr. J. A. Currie, Mr. T. B. McMurray, with Dr. A. A. Zabow and Dr. T. J. Dry as co-opted members. The Executive Committee agreed to this proposal.'

Council *Confirmed* the action of the Executive Committee.

Council then agreed to consider the Report which had been submitted by the *ad hoc* committee and which appeared in the Annexures.

Prolonged discussion followed, during which time two proposals were handed in and later withdrawn.

Eventually it was proposed by Dr. Sichel, seconded by Mr. McMurray and *Unanimously Resolved* that a Committee be set up situated in Pretoria, to consider comprehensively in the light of the work of the Committee on the Economics of Medical Practice and the memorandum prepared by the *ad hoc* committee, what further steps should be taken to initiate a medical insurance plan that could be supported by the Medical Association.

Council further *Agreed* that the earlier Committee, charged with the investigation of this matter, be discharged with thanks for their services.

After further discussion it was proposed by Dr. Struthers and generally *Agreed* that the new Committee on the Economics of Medical Practice should consist of the five members of Council resident in Pretoria, namely, Dr. Waks, Dr. Ziady, Dr. Struthers, Dr. Epstein and Mr. J. G. A. du Toit, together with Mr. G. T. du Toit and Dr. M. Shapiro, and that Dr. Waks be the Convener of the Committee.

46. *Implementation of Policy on Open Panels:* The Report stated: 'At the last meeting of Council it was resolved "that the policy of the Association as defined in the previous resolution of Federal Council be reaffirmed and that a committee be appointed to investigate and report on the best way of implementing this policy reasonably in the interest of the public and the profession." It was further agreed "that the Executive Committee be appointed to do this work" and "that the initiative should lie with the Cape Town members of the Executive Committee." The recommendations of the Cape Town members of the Executive Committee will be considered by the whole Executive at its meeting on 26 March 1957, and a report will be made to Council accordingly.'

The report which had been prepared had been submitted to all members of Council.

After discussion it was felt that a more comprehensive memorandum was necessary, and it was proposed by Mr. Wolfowitz, seconded by Mr. McMurray and *Resolved*, 'That the matter of the "open panel policy" be referred back to the Executive Committee for instruction as to how this policy can be implemented.'

47. *Scientific Exhibitions at Congress:* The Report stated: 'The Honorary Organising Secretary of Congress enquired whether it was the intention of Federal Council in accepting the memorandum prepared by Dr. H. O. Hofmeyr regarding future Scientific Exhibitions, to institute a Gold Medal, a Silver Medal and a Bronze Medal for the three best exhibits, with certain Certificates of Merit. The Committee agreed that no medals should be awarded in this connection but that it would be reasonable to have certificates in recognition of the excellence of exhibits.' *Noted.*

48. *Enquiry into Affairs of Transvaal Branches:* The Report stated: 'The appointment of a Committee of Enquiry was left to the Executive Committee. The Committee agreed that Dr. R. Schaffer (a member of Federal Council) and Mr. N. McLeod of Pretoria (a business efficiency expert) be asked to constitute the Committee of Enquiry.' *Noted.*

49. *Appointment of Assistant Secretary (Transvaal):* The Report stated: 'At the request of Dr. Struthers, the Executive Committee agreed that in appointing Dr. P. D. Combrink to the post of Assistant Secretary (Transvaal) he commence on the £1,500 notch of the salary scale £1,250×50—1,750 plus cost of living allowance.'

On the matter being put to the vote, Council *Confirmed* the action of the Executive Committee.

50. *Office for Assistant Secretary (Transvaal):* The Acting Chairman pointed out that it would be necessary for the Assistant Secretary in the Transvaal to have permanent occupation of premises and to have adequate secretarial assistance. He had obtained the option on three rooms in Medical Centre, Pretoria, and required authority to proceed with the signing of a lease.

Council generally *Agreed* that the Assistant Secretary be authorised to arrange the necessary accommodation and secretarial assistance in connection with the establishment of his office in Pretoria.

Council adjourned for dinner from 6.15 p.m. to 8.10 p.m.

Dr. Sichel was in the Chair.

51. *Transfer of Durban Medical Faculty:* At the outset Dr. Shapiro proposed, and Council *Agreed*, that this matter be taken in committee.

After long discussion Council went out of committee and *Unanimously Reaffirmed* the resolutions taken in committee. They were as follows: '(1) That as the Medical Association of South Africa is vitally interested in medical education in South Africa, it views with grave concern the implications arising out of the decision of the Government in its Separate University Education Bill in which it intends to sever the Faculty of Medicine from the University of Natal, and appeals to the Government to reconsider this decision. (2) That the Minister of Education be requested to receive a deputation from this Association.'

Council further *Agreed* that the resolutions should be made known to the Minister of Education by telegram, but that they

should not be released for publication otherwise than in the *South African Medical Journal*.

Dr. Sichel then moved the adoption of the Executive Committee's Report. This was *Carried with Acclamation*.

FEDERAL ETHICAL COMMITTEE'S REPORT

52. *Report of Federal Ethical Committee:* A Report by the Secretary was submitted, in which it was stated that there had been no meetings of the Federal Ethical Committee since the last meeting of Council. Two matters, however, had been placed before the Committee for opinion. They were as follows:

53. *Practice in Uitenhage:* The Cape Midlands Branch had submitted a resolution reading: 'It was resolved that it was quite ethical for a doctor from Port Elizabeth to operate in Uitenhage whether he be a general practitioner or specialist, but it is desirable that all the arrangements be made through the patient's family doctor, or, if he has no doctor, through a local practitioner. It was emphasized that there was no difference between the doctor being a specialist or general practitioner as he would, in any case, be acting as a consultant. It was his duty, however, to ensure that adequate arrangements had been made for the patient's pre- and post-operative care. The opinion was expressed that it was the individual right of any doctor to cooperate, or not, with another general practitioner or specialist, but it is entirely wrong to organize opposition amongst a number of doctors.'

The Branch desired to know whether its opinion was supported, and members of the Federal Ethical Committee unanimously supported the Branch in its opinion.

Council *Confirmed* the action of the Federal Ethical Committee.

BENEVOLENT FUND

55. *Report of Management Committee of Benevolent Fund:* Dr. Sichel presented this Report and stated that there had been two meetings of the Committee since the last meeting of Council. The average attendance had been ten members. The following items were contained in the Report:

56. *Applications for Assistance:* The Report stated: 'The following applications for assistance received the attention of the Committee: (*a*) Cape Western Branch—Mrs. R.K., £22 10s. 0d. per month as from 1 October, 1956; (*b*) Southern Transvaal Branch—Mrs. T.B., £12 10s. 0d. per month as from 1 October, 1956; (*c*) Northern Transvaal Branch—Dr. D.P.A., an outright grant of £50; (*d*) O.F.S. & Basutoland Branch—Mrs. L.A.A., £5 per month as from 1 January 1957. By virtue of the authority vested in it, the Management Committee has made these grants and now seeks the confirmation of Council.'

By vote, Council *Confirmed* the grants which had been made.

57. *Grants for 1957:* The Management Committee recommended to Council that the following grants be made for 1957: Cape Eastern Branch—Mrs. L.A. £150 per annum, Mrs. P.A. £240 per annum; Cape Western Branch—Mrs. O.G.F. £180 per annum, Mrs. J.R.M. £150 per annum, Mrs. G.E. £25 per annum, Mrs. R.K. £270 per annum; East Rand Branch—Mrs. G.E.L. £180 per annum; Natal Coastal Branch—Mrs. E.M.H. £180 per annum, Mrs. A.M.P. £180 per annum, Mrs. E.M.R. £180 per annum; O.F.S. & Basutoland Branch—Mrs. M.A.L. £150 per annum, Mrs. L.A.A. £60 per annum; Southern Transvaal Branch—Mrs. M.G.M. £150 per annum, Mrs. M.R.D. £150 per annum, Mrs. A.M. £150 per annum, Mrs. M.F.S. £150 per annum, Mrs. T.B. £150 per annum, Mrs. E.C. (non-member) £150 per annum, Mrs. S.R. (non-member) £120 per annum; Royal Medical Benevolent Fund—Mrs. F.W. £90 per annum; Officers' Association, British Legion—Mrs. D.M.G.F. 26 gns. per annum.

The Secretary stated that two further recommendations were made to Council as follows: Northern Transvaal Branch—Mrs. G.E.K. £120 per annum; Southern Transvaal Branch—Mrs. M.A.P. £120 per annum.

By vote, Council *Unanimously Confirmed* the recommendations of the Committee.

58. *Donations and Legacies:* The Management Committee recorded with thanks the following donations and legacies: Griqualand West Branch £38 3s. 3d.; Dr. S. M. de Kock £100; Southern Transvaal Branch £583 3s. 2d.; the late Mr. T. Lindsay Sandes £250. *Acclamation*.

59. *Report of Workmen's Compensation Act Sub-Committee:* The Convener, Dr. Vercueil, reported that the revised Schedule of Fees under this Act had come into operation on 1 September, 1956. He reported further as follows:

60. *Physical Medicine Specialists:* The Report stated: 'All the Physical Medicine Specialists Group appeared to be entirely satisfied. However, the 25% increase paid on the old tariff was inadvertently overlooked when fees were laid down for physiotherapeutic treatments for injured Native workmen, with the result that the new fees laid down in Item 29(1)a were fixed at the old rates, viz. 7s. 6d. for General Practitioners (Physiotherapists) and 12s. 6d. for Specialists in Physical Medicine. On behalf of the Workmen's Compensation Act Sub-Committee, representations were made to the Commissioner, with the result that the existing rate was amended to read 10s. and 15s. respectively.' *Noted*.

61. *Dermatologists:* The Report stated: 'For report, patch test and two subsequent consultations Dermatologists were paid £6 10s. 0d. They were overpaid according to one prominent Dermatologist. Under the revised tariff they are being paid £5 10s. 0d. The Dermatologists had a representative present when dermatological fees were discussed, and did not notice it. One only heard of this after the fees were gazetted. An attempt was made to rectify this with the Commissioner; however, it proved futile. With all other procedures they were entirely satisfied with the revised schedule.' *Noted*.

62. *Complaints by Medical Practitioners:* The Report stated: 'A few complaints were received from medical practitioners that the Commissioner had not paid them in full. These cases were taken up with the Commissioner immediately. In every instance the Commissioner was perfectly right.

'On the whole the profession is entirely satisfied with the new Schedule of Fees, although there have been a few discontented General Practitioners in Johannesburg about the consultation and visiting fees for General Practitioners. The fee of 10s. was only accepted after consultation with the Chairman of the National General Practitioners' Group.' *Noted*.

Dr. Vercueil stated that a further meeting was to be arranged with the Commissioner during the following months. *Noted*.

63. *Sub-Committee on Groups within the Association:* The Secretary reminded members that at the meeting during the previous evening he had reported on this matter, but that discussion had been deferred (vide Minute 32).

Discussion followed, but no decision was made. Eventually the Chairman stated that the matter would be discussed further on the following day.

Council adjourned at 11.15 p.m.

FRIDAY, 29 MARCH

The meeting commenced at 9.10 a.m. Dr. Sichel was in the Chair.

64. *Durban Medical School:* The Chairman stated that the question had arisen as to whether the Minister should be informed of the resolution taken by Council.

After short discussion it was proposed by Dr. Shapiro and generally *Agreed* that a personal telegram be sent to the Minister at the Houses of Parliament, stating that no public release would be made at this stage.

65. *Sub-Committee on Groups within the Association:* Discussion on this subject continued, and it was proposed by Dr. Turton, seconded by Dr. Lee, 'That the Railway Medical Officers' Group and the District Surgeons' Group be allowed direct negotiation with the Railways and Harbours Sick Fund and the Department of Health respectively, when the negotiations are Union-wide in character, provided that local appointments shall fall within the scope of the Branches in accordance with the Association's policy in regard to Contract Practice.'

After discussion an amendment was proposed by Dr. Struthers, seconded by Dr. Vercueil, 'That the rules concerning the Constitutions of Groups, which were placed before Federal Council at the last meeting, be accepted, but that the Railway Medical Officers' Group, The Mines Benefit Societies Medical Officers' Group and the District Surgeons' Group be excluded from these rules.'

A further amendment was proposed by Dr. Shapiro, seconded by Mr. Wolfowitz, that the words 'direct negotiation' in Dr. Turton's proposal be deleted and replaced by the words 'to initiate negotiations'.

After much further discussion, Council generally *Agreed* that no vote be taken on either the resolution or the amendments but that the matter be referred back to the original Committee

for further consideration, and that the Committee have the right to call on such medical men as they thought fit to give evidence.

CONTRACT PRACTICE

66. *Report of Central Committee for Contract Practice:* The Chairman of the Committee, Dr. Vercueil, presented his Report, stating that joint meetings between his Committee and representatives of the Advisory Council of Medical Aid Societies had been held on 23 November, 1956, and 25 March, 1957. A further joint meeting between the Committee and representatives of Approved Medical Aid Societies had been held on 1 and 2 March, 1957. At the meetings held during 1957, representatives of the various Groups within the Association had been present, and the discussion had been both amicable and satisfactory.

67. *Tariff of Fees for Approved Medical Aid Societies:* It was reported that the discussions referred to above had resulted in the adoption of a new Tariff of Fees, which would mean an increased annual expenditure by the Societies of some 15 per cent. Various amendments had been made in the draft schedule which had previously been adopted by Council, as the draft schedule would have meant an overall increase of 22 per cent. Generally the increases which had been granted for general practitioners had resulted in an overall increase of 28 per cent in these fees. Dr. Vercueil paid tribute to the co-operation of the representatives of the Medical Aid Societies and to the representatives of the Groups, indicating that the round-table discussions had greatly increased the possibility of unanimity.

Council generally *Confirmed* the action of the Chairman of the Committee in regard to the meetings which had taken place.

The Chairman stated that the Committee recommended that the new Tariff of Fees be stabilised for three years, unless a radical change in economic conditions occurred during the period which might necessitate amendments.

After discussion it was proposed by Dr. Shapiro, seconded by Dr. Struthers and *Resolved* that the three-year period be agreed to, with the exception of Consultations and Visiting Fees for General Practitioners, about which the Council reserved the right to negotiate again during the period.

The schedules submitted to Council by the Committee were *Confirmed* after certain amendments had been suggested.

It was proposed by Mr. Wolfowitz, seconded by Mr. Joubert and *Resolved* that Items 51, 53, 54 and 55 of the Surgical Schedule, in regard to operations of a urological nature, should stand, and that Items 52, 54, 56 and 57 of the Urological Surgeons' Schedule be amended to conform to that of the Surgeons' Schedule.

Dr. Shapiro mentioned the question of fees for Blood Transfusions. Council agreed that any further anomalies which might be pointed out could be dealt with by the Committee before the Tariff was printed.

The Chairman indicated that it was probable that the Tariff would come into operation on 1 July, 1957. *Noted.*

68. *Continued Recognition of Societies:* Dr. Vercueil reminded the Council that at its meeting in April, 1956, a rule had been laid down requiring Societies to give a written undertaking that they were prepared to supply all relevant information required by the Association in order to retain their approval by the Association. Representatives of the Societies had agreed to this, on condition that the word 'reasonable' was inserted before the word 'information'. The Committee recommended to Council accordingly. Council *Agreed.*

MEDICAL AID SOCIETIES CEILING

69. *Average Income and Ceiling for Members of Medical Aid Societies:* It was stated that the Societies had indicated that they desired the deletion of the rule regarding the ceiling for members of Medical Aid Societies, because the number of persons earning over £2,500 per annum was very small. Difficulties were also experienced in applying this rule because Secretaries of Societies were not supposed to know what the various members earned, and it was not the policy of the employers to disclose to anyone what an employee might earn. It was suggested that the average income was regarded as sufficient to keep control of the number of persons of high income who could be included in a Society. Figures given for 66 Societies with a membership of 75,803 and 87,086 dependants showed that 624 earned over £2,500, while 75 per cent earned under £750 gross. In other words, ·84 per cent of members earned over £2,500. In another Society of 2,400 members, only 9·5 per cent earned over £600 per annum. Thus, it was pointed out, the Societies catered for a largely sub-economic group, while the higher-paid members subsidised the lower-paid members to the extent of one to three.

It was proposed by Mr. Wolfowitz, seconded by Dr. Shapiro, 'That this matter be deferred until such time as agreement has been reached between the Medical Association and the Medical Aid Societies on fees for general practitioners' visits and consultations.'

An amendment was proposed by Mr. Currie, seconded by Dr. Gluckman, 'That the formula devised for members of Medical Aid Societies, whose income rises during their membership to £2,500 or over, recorded in Minute 75 of the Minutes of the Council meeting of October, 1956, be applied to all members whose income is over £2,500.'

After further discussion, Mr. Currie's amendment was put to the vote and *Carried.* It was also *Carried* as the substantive motion.

70. *Earmarking of Benefits for Doctors' Fees:* It was reported that the Committee had investigated the question of the Medical Aid Societies giving a certain preference in the payment of doctors' accounts by earmarking a portion of the benefits to which their members were entitled. The representatives of the Societies had explained that there were many practical difficulties in the way of acceding to this request. The administrative work of the Societies would be increased, and it was their aim to keep administrative costs as low as possible. The Societies had suggested that difficulties experienced by doctors in regard to the payment of their accounts could be brought to the notice of the Regional Councils of Medical Aid Societies who would investigate and try to solve the difficulty. They had suggested further that doctors should advise a Society on the treatment which was to be carried out, so that they could be told if the member's benefits were going to be sufficient to meet the costs. (See Paragraph 2 of the Preamble to the Tariff). The Societies felt that the direct approach of practitioners to the respective Councils would expedite the handling of difficulties instead of first referring to the Branch of the Medical Association or its Contract Committee. For the convenience of members it had been agreed that the addresses of the Regional Councils of Medical Aid Societies could be published in the *Journal* for information.

The Committee recommended the adoption of these suggestions, and Council *Agreed.*

71. *Definition of a Dependant:* The definition of a dependant, adopted by Council, was not acceptable to the representatives of Medical Aid Societies, because definitions varied so widely in the different Societies. It was pointed out that employing organisations would not allow dependants who were not eligible, to remain in a Society, because the employer contributed to the Society on the basis of the subscriptions of the members. The Societies were just as anxious to exclude persons who should not be included as dependants of members, and suggested that abuses in this connection could always be brought to the notice of the Regional Councils of Medical Aid Societies.

The Committee recommended to Council that this rigid definition be not applied. Council *Agreed.*

72. *Overdue Accounts:* Difficulties had been experienced by members of the Association when applying the procedure of advising a Society that an account was overdue. It was mentioned that frequently a doctor was informed that the time limit for submitting claims by the member had lapsed. When this matter was discussed with representatives of the Societies, they had stated that the investigation of reports took up much time as they frequently received enquiries before the expiry of the three months stated in the Tariff book. They therefore recommended that the last paragraph in Item 2 of the General Preamble to the Tariff should be amended as follows: 'If payment of an account is not received after three consecutive monthly accounts have been rendered to the member, the fourth monthly account giving the full name and address (home and business, if possible) of the member, shall be sent direct to the Society concerned, bearing the words written prominently in red "Three Months Overdue—Please Investigate".' It was said that the Medical Aid Societies had undertaken to expedite payment in these cases.

The Committee recommended that the paragraph quoted above be adopted. Council *Agreed.*

73. *Claim Forms:* It was reported that further discussions had taken place regarding the abolition of Claim Forms, but it was found that several Societies still adhered to them. The Advisory

Council of Medical Aid Societies had reported that it had appointed a Committee to go into the question with a possibility of producing a standard Claim Form. It would be some time before a further report on the matter could be made. *Noted.*

REVISION OF FEES

74. *Revision of Fees on a Geographical Basis:* The Committee had considered the resolution passed by the Southern Transvaal Branch which had been forwarded to Federal Council, that the Branch intended to implement its resolution noted by Council in October, 1955, unless the Central Committee for Contract Practice was instructed to discuss a Tariff of Fees on a regional basis at the meeting with Medical Aid Society representatives on 1 and 2 March, 1957. The resolution of October, 1955, stated the Branch's intention to revert to the position where the Southern Transvaal Branch had control of all Contract Practice matters affecting its members.

It was reported that the Committee could not express an opinion on the intention of the Branch, but that it reiterated its opinion which had been expressed at previous meetings, that it did not support the idea of having fees laid down on a geographical basis. The Committee felt that it would increase the administrative work of the Societies and could also create difficulties between the various Branches if the discrepancies in the Tariff did not meet with the approval of all the practitioners concerned. The matter had been discussed at the joint meeting with the representatives of Medical Aid Societies, who had expressed their objection to such a procedure.

In the circumstances the Committee recommended to Council that this matter be not proceeded with, as the Committee was unanimous that it was undesirable both in principle and on account of the administrative difficulties involved.

Considerable discussion followed, during which the suggestion was again made that fees for consultations and visits of general practitioners should be excluded from the Tariff up to a certain amount, so that ordinary customary fees could be charged.

Finally Council *Agreed to Accept* the recommendation of the Committee.

75. *General Practitioners' Group—Recommended Fees Applicable to Medical Aid Societies:* It was reported that the memorandum on this subject, prepared by the Group, had been passed to the Committee shortly before the joint meeting held on 1 March, 1957. The memorandum dealt with the consultation and visiting fees of general practitioners and the fees for weekend visits and night calls. Although these fees had not been considered by Council, the Committee had discussed them with representatives of the Group in a short meeting immediately prior to the joint meeting and agreed to discuss the matter with representatives of the Medical Aid Societies. The representatives were not prepared to accept a uniform fee for the whole country, as they had made the differentiation in fees for Johannesburg in order to accommodate the practitioners there for their travelling and the delay in getting through the city. The increased fees for weekend and night calls of 27s. 6d. were again discussed at a later date with the Advisory Council of Medical Aid Societies and representatives of the Group, when it was agreed that fees for weekends would be withdrawn and the fee for night calls was increased to 25s. An increase of 2s. 6d. had been obtained for visits and consultations only a year previously, and the Committee felt that it could not now approach the Societies for a further increase, particularly as the new Tariff book had to be issued by 1 July, 1957.

As the fees for visits and consultations by general practitioners had already been excluded from the three-year period referred to in Minute 67 above, Council agreed that there should be no further resolution taken on this matter and that the fees were to be the subject of further negotiation.

76. *Northern Medical Aid Society:* It was reported that the Society had advised that further companies had been included in their number, and asked for the consent of the Association. On representations from the Southern Transvaal Branch, the Committee agreed that the approval of the Association should first have been obtained. In the circumstances the Committee recommended to Council that the inclusion of the new Societies be not approved, as prior sanction had not been sought by the Society. It recommended further that if the Society persisted in further incorporations the Council should withdraw the Association's approval of the Society. Council *Agreed.*

77. *Metal Box Company (S.A.) (Pty.) Ltd. Medical Aid Society:* It was reported that the Committee had deferred the question of members of this Society obtaining medical attention through the Vanderbijlpark Medical Benefit Fund, for a further six months. *Noted.*

78. *Natal Industries Medical Aid Society:* It was stated that this Society had also admitted firms, members of the Natal Chamber of Industries, to the Society without receiving prior approval of the Association. The Committee recommended that the same procedure be adopted as was recommended for the Northern Medical Aid Society. Council *Agreed.*

79. *Approval of New Societies:* The Committee recommended that recognition be granted to the following Societies:

(*a*) Prudential Insurance Company (Pty.) Ltd. Medical Aid Society.
(*b*) Syfrets Medical Aid Society.
(*c*) Union Liquid Air Company (Pty.) Ltd. Medical Benefit Society.

Council *Agreed* that these Societies be *Approved*, but in the case of the last-named Society approval was contingent on satisfactory replies being received to certain comments on the Rules.

80. *Amendments to Constitutions:* It was reported that the Committee recommended that Council accept amendments to the Constitutions of the following Societies, as they were in conformity with the Rules for Medical Aid Societies and did not affect medical practitioners adversely:

(*a*) A.A. Mutual Medical Aid Society.
(*b*) Algoa Medical Aid Society.
(*c*) Bloemfontein Municipal Employees' Medical Aid Society.
(*d*) Chamber of Mines Medical Aid Society.
(*e*) Civil Service Medical Benefit Association.
(*f*) Escom (N.C.U.) Medical Benefit Society.
(*g*) Hunt, Leuchars & Hepburn Medical Aid Society.
(*h*) Northern Rhodesia European Civil Servants' Medical Aid Society.
(*i*) Printing Industry Medical Aid Society.

Council *Agreed* that these amendments be *Approved.*

81. *Examination Fee for Entrants to Medical Aid Societies:* It was reported that in regard to the examination of dependants of members for admission to Societies, the fee set out in paragraph 1 of the Preamble should remain at 10s. 6d. if only an ordinary certificate of health was required. If a full examination, entailing the completion of a detailed report, was required, the fee should be £1 1s. 0d. as for members. Council *Agreed.*

82. *Advertisements in the Journal:* It was stated that the Committee's attention had been drawn to the vague wording of certain advertisements, in which the nature of the service required and the locality of the appointment were not specifically mentioned. It was thought that such advertisements did not always arouse the interest of practitioners who might be suitable applicants for these posts. The Committee recommended to Council that advertisers should be requested to be more specific in their advertisements. Council *Agreed.*

83. *Incorporation of the Cornelia Colliery by the Mines Benefit Society:* It was reported that the Mines Benefit Society had incorporated the employees of the Cornelia Colliery. These persons had been formerly included in the Vereeniging Estate Sick Benefit Fund and had been served by general practitioners in Vereeniging on a per capita basis. The incorporation had been carried out without prior consultation with the panel doctors, who had merely been notified of the termination of their appointments but were invited to re-apply for appointments at a lower remuneration. The doctors concerned had refused to do this, and appointments had eventually been made without advertisement, of two full-time doctors by the Anglo-American Corporation to which the Mines Benefit Society paid the subscriptions of the employees of the Collieries. It was reported further that specialists at Vereeniging who had previously attended these patients, were now no longer required to render services to the employees of the Colliery as these persons were now included in the panels of the specialists in Johannesburg appointed by the Mines Benefit Society. It was stated that the Medical Council had ruled that no infringement of ethical rules had been made.

Full copies of the relevant correspondence in connection with this matter had been submitted to members of Council for their information.

Having considered the matter, the Committee had agreed that it could only accept the fact that these appointments had been made and that they could not now be disturbed, but it recommended

to Council that extreme disapproval of the action of the Mines Benefit Society be expressed. Council *Agreed.*

84. *Klerksdorp District Mines Sick Benefit Society:* It was stated that the Potchefstroom Division had, through the Southern Transvaal Branch, requested Council to consider amending the Rules for Benefit Societies in order that this Society could be approved. The chief obstacle appeared to be that the income of the members of this Society was too high for the Branch to grant it recognition. The question of changing the Society so that it could become a Medical Aid Society, had been considered, but the additional expenditure involved made this impossible.

The Committee recommended to Council that further steps be taken by the Southern Transvaal Branch to resolve the difficulties connected with this Society, and that the services of the Executive Committee of the Central Committee for Contract Practice be offered to the Branch in conferences with the Society for this purpose.

In the discussion which followed, it was explained that some of the members of the Southern Transvaal Branch considered that the Benefit Society had received tentative recognition together with other Societies at the time the Mines Benefit Society came into being. The doctors serving the Society, however, were not assured of this point and considered that there were some features in connection with the Society which needed investigation before full approval could be given. It was felt that the doctors providing the services were holding appointments not in conformity with the requirements of the Association. The Branch had been urged by the Division to grant recognition to the Society, but the Rules of the Association precluded the Branch from taking this step. Amongst other things, it was pointed out that certain persons who were not bona fide members of the Mines were members of the Society.

It was proposed by Dr. Shapiro that the Society should be accorded the same type of recognition as was accorded to the Mines Benefit Society, provided that the Society came to terms with the doctors on the matters in dispute. Council *Agreed.*

Council also *Agreed* to the recommendation of the Committee.

85. *Sasol Medical Aid Society:* It was recalled that this Society, which had been established first as a Medical Aid Society, had been allowed to become converted to a Medical Benefit Society for certain reasons. It was recognised that the Society had consulted the Association and had co-operated in every respect. The Society had, in fact, been encouraged to bring any further difficulties to the Committee for negotiation. The Committee had received a deputation from the Society, at which concern had been expressed that the number of doctors practising in Sasolburg had been decreased, and it was felt that if they continued to decrease in number it might be necessary for the Society to appoint full-time medical officers. Good and attractive salaries had been suggested for such appointments if they were to be allowed.

It was reported that the Committee was of opinion that the panel system had not been tried long enough and that wide-spread advertising for medical practitioners had not yet been tested. The Committee therefore recommended to Council that the full-time appointments be not approved, but that in order to assist the Society an inspection in loco be promised so that the matter could be thoroughly discussed. Council *Agreed.*

Dr. Vercueil then proposed the adoption of the Report of the Central Committee for Contrat Practice. This was *Carried with Acclamation.*

HEAD OFFICE AND JOURNAL COMMITTEE

86. *Report of Head Office and Journal Committee:* Dr. Sichel presented the Report, stating that there had been six meetings of the Head Office and Journal Committee since the last meeting of Council, the average attendance being eleven members. He reminded members of Council that they had received the Minutes of the Committee meetings and so were informed regarding all that had taken place. In the circumstances, he said, he would only refer to those matters which required decision by Council. They were as follows:

87. *Appointment of Editor:* The Report stated: 'At the last meeting of Council it was resolved "that the matter of the appointment of an Editor be referred back to the Head Office and Journal Committee to be dealt with in their discretion so that the Committee shall be in a position to make a firm recommendation at the next meeting of Council." The Committee has dealt with this matter in the light of the applications before it, and its firm recommendation to Council is "that the present position be maintained for a further period, as the Editor is able to carry out all the duties of his post with the assistance he is at present receiving." '

Considerable discussion followed, at the commencement of which Council *Agreed* to go into committee.

While in committee, Council adjourned for lunch from 1 p.m. to 2.15 p.m.

Discussion continued, and it was eventually *Agreed* to go out of committee and that the resolution which had been carried in committee be *Confirmed.* The resolution, which had been proposed by Dr. Shapiro and seconded by Dr. Broomberg, was to the effect that the words 'as the Editor is able to carry out all the duties of his post with the assistance he is at present receiving' be deleted from the recommendation of the Head Office and Journal Committee and be replaced by the words 'and that the matter be left in the hands of the Head Office and Journal Committee.' This was *Carried Unanimously.*

88. *Endowment Assurance:* The Report stated: 'The question of providing a suitable pension scheme for members of the Association was referred to the Head Office and Journal Committee over a year ago. The Committee advised against such a scheme and suggested at the time that members should be encouraged to make their own provision for the future by means of endowment assurance. At the time that this matter was discussed by Council it was proposed at the meeting that Messrs. Price Forbes be appointed the Association's brokers in order that they might prepare a pension scheme for consideration. The Council voted against this proposal. In October last the Committee considered a form of endowment assurance provided by a leading life assurance company and agreed that this should be put before the profession from the Medical Insurance Agency. A considerable number of enquiries were received as a result. The Southern Transvaal Branch disagreed with the Committee in recommending this form of endowment assurance to members of the Association and has put forward the following resolution for debate by Council: "This Branch Council disapproves of the unilateral action of the Head Office and Journal Committee in giving approval to a pension scheme which had not been debated or approved by Federal Council." '

Certain members amplified the resolution put forward by the Southern Transvaal Branch, and after some discussion the Secretary explained the whole position. Finally Dr. Shapiro proposed that the explanation of the Secretary be accepted and noted. Council *Agreed.*

89. *Motor Car Insurance:* The Report stated: 'As a result of complaints placed before the last meeting of Council, this matter was referred to the Head Office and Journal Committee for investigation. The Secretary visited the Managing Director of the firm in Johannesburg and followed his visit with numerous letters requesting a full statement regarding the motor car insurance scheme in relation to the Association.'

A letter from the Managing Director of the firm was submitted.

Dr. Gluckman drew attention to a letter, copies of which had been circulated to members of Council. This dealt with motor car insurance as put forward by another insurance company. He proposed, and Council *Agreed,* that the matter be left in the hands of the Head Office and Journal Committee.

90. *Distribution of Extra Copies of Circulars to Branches:* Dr. Sichel stated that this matter had been discussed by the Head Office and Journal Committee, and added that the Executive Committee recommended that the Branches should be invited to state how many copies of such circulars they would require. Council *Agreed* accordingly.

91. *Public Relations:* The Report stated that the Committee had considered a letter in which services were offered to the Association as public relations experts. The Committee had decided that the matter should be placed before Council, but that the Committee would recommend to Council that the offer be not accepted.

Council *Agreed* that the offer be not accepted.

92. *Emoluments and Allowances of Executive Staff:* The Report stated: 'The Committee has considered the emoluments and allowances of the executive staff and recommends to Council as follows:

(*a*) That Dr. Marchand be advanced two notches on the scale £1,250 × 50 — 1,750 as from 1 January, 1957, he being on the £1,500 notch at present.

(*b*) That the Secretary and the Editor receive an entertainment allowance of £75 per annum as from 1 January, 1957, being an increase of £25 on that which they have received up to the present.

(*c*) That the Associate Secretary's entertainment allowance be increased from £25 to £50 per annum as from 1 January, 1957.

(*d*) That Dr. Combrink be paid an entertainment allowance of £50 per annum as from 1 January, 1957.'

On the proposal of Dr. Vercueil, Council *Unanimously Agreed* to paragraph (*a*).

Dr. Shapiro proposed, seconded by Dr. Adler, that paragraphs (*b*), (*c*) and (*d*) be referred back to the Head Office and Journal Committee. The Honorary Treasurer said that he would agree, but asked that the Committee be given power to act. Council *Agreed* accordingly.

93. *Northern Transvaal Branch Medical Library:* The Report stated: 'The Committee has discussed the transfer of the Northern Transvaal Branch Medical Library and Archives to the University of Pretoria, under certain conditions, it being understood that the Branch wishes this to be done. The conditions set out are as follows:

'(1) That the Historical Library shall retain its entity within the Library Building, and that a plaque shall state that the Northern Transvaal Branch had contributed the nucleus of this section.

'(2) That in view of the fact that a central body does the buying for the Medical Library and that such a body may not necessarily be sufficiently well informed as to the special needs of this section, that a small sub-committee be formed to foster its interests, and that it have authority and aid to do the special buying of historical medical books.

'(3) Apart from the annual aid the Library will receive from the Medical Association of South Africa, the Northern Transvaal Branch is making monetary contributions, so we therefore ask that in addition to such representation as the Medical Association may have on the Library Committee, it shall also have representation on the sub-committee of the Historical Section.

'(4) Prof. Guthrie, Lecturer in Medical History at the University of Edinburgh, and famous Historian, has been a staunch friend to the Library of Medical History. He has made valuable personal gifts to the Library, has advised us constantly and done much of the buying. He has offered to continue with his valuable services. In appreciation the Northern Transvaal Branch is considering obtaining a photographic enlargement of Dr. Guthrie, which will be of modest dimensions, and we trust that you will consent to having this photograph suitably placed within the Library Building.

'As recognition was orignally given to the establishment of the Northern Transvaal Branch Medical Library as a National Archives by Federal Council, the Head Office and Journal Committee has agreed to recommend to Council that the position be accepted.'

Council *Agreed* to the recommendation of the Committee.

94. *S.A. Journal of Laboratory and Clinical Medicine:* The Report stated: 'The question of the future of this Journal was referred to the Committee at the last meeting of Federal Council (see Minute 26). The Committee has unanimously agreed to recommend to Council that the *S.A. Journal of Laboratory and Clinical Medicine* be continued as the Association's quarterly publication for papers of the nature indicated in its title, and that the administration details to accomplish this purpose be left to the Head Office and Journal Committee. (Reference to this matter will be found in the Minutes of a Special Meeting of the Committee held on 8 March, 1957.)'

Discussion followed, and when the recommendation of the Committee was put to the vote it was *Carried Nem. Con.*

95. *Re-organisation of the Association:* It was agreed that it would be appropriate at this stage to consider the resolution put forward earlier (see Minute 35 above) by Dr. Schaffer and Dr. Goldberg, reading: 'That a Committee be appointed to investigate all aspects of Medical Association activity and to make recommendations as to the future organisation of the Association.'

In the discussion which followed, the Chairman and other members of Council referred to the Association's cumbersome machinery and the ineffectiveness of the Executive Committee, both of which resulted in delay in dealing with affairs.

On being put to the vote, the resolution was *Carried.*

Council *Agreed* that the Committee should consist of Dr. Sichel with power to co-opt, and that the memorandum prepared by Dr. Sichel's Committee should be considered in the first instance by the Executive Committee.

Dr. Sichel then moved the adoption of the Report of the Head Office and Journal Committee. This was *Carried.*

PARLIAMENTARY COMMITTEE

96. *Report of Parliamentary Committee:* Dr. Struthers presented this Report and stated that during the past five months since the last meeting of Council a large number of very important issues had been dealt with by his Committee. They were as follows:

(*a*) *Income Tax Concessions in Relation to Overseas Post-Graduate Study Tours by Medical Practitioners:* It was indicated that certain additional relief would be afforded in due course. *Noted.*

(*b*) *Labelling of Blood Containers:* It was stated that a deputation had been received by the Minister of Health, and the matter was receiving further attention by the Secretary for Health. *Noted.*

(*c*) *Locations in the Sky Act:* After investigations and interviews, the Committee recommended to Council that the decisions of the Non-European Affairs Department of the Johannesburg Municipality be accepted and that no further action be taken in this matter. *Agreed.*

(*d*) *Pneumoconiosis Act, June* 1956: It was reported that the Committee had examined this Act with particular reference to Sections 27, 29 and 31. It considered that the new Act made no essential difference to the terms of the old Act and that no action by the Association was necessary. *Noted.*

(*e*) *District Surgeons:* It was stated that all members of Council would have learned of the increases in salaries and allowances and other concessions granted to district surgeons. The Committee placed on record its grateful thanks to Mr. J. G. A. du Toit who had devoted much time and energy to interviews and discussions with the Secretary for Health on this matter. *Noted.*

(*f*) *Medical Auxiliaries Bill:* It was reported that this Bill was not being proceeded with during the present Session of Parliament and that the whole principle of the registration of auxiliaries was being investigated by a Committee of the S.A. Medical and Dental Council. *Noted.*

(*g*) *Ethical Rules* 16, 17, 19 *and* 19(*bis*): Dr. Struthers reported on a meeting which had been held between representatives of the Association and the Executive Committee of the S.A. Medical and Dental Council. He referred to a memorandum which had been prepared by the Committee and which had been handed out at the meeting.

The Secretary stated that the Executive Committee had agreed to recommend to Council 'That, provided Council approves the draft memorandum regarding Rule 19 (Advertising) of the S.A. Medical and Dental Council's Rules, the Parliamentary Committee be empowered to act on behalf of the Association with legal assistance, in advising the Medical Council of the Association's desires.'

On being put to the vote, the Executive Committee's recommendation was *Carried Nem. Con.*

(*h*) *Dr. Mahlangeni, East London:* Dr. Struthers outlined all the action which the Committee had taken in an attempt to protect the practice of Dr. Mahlangeni. In view of all that had passed, his Committee recommended that no further action be taken. Council *Agreed.*

(*i*) *Medical Officers—Union Defence Forces:* Dr. Struthers reported on the negotiations which had taken place between his Committee and the Surgeon-General. Various documents were submitted, and he stated that the Executive Committee had agreed that no further action be taken. Council *Agreed.*

(*j*) *Retiring Age of Medical Officers:* Council was reminded that it had agreed that the age of 60 years should be laid down as the retiring age for part-time clinical hospital staff members. It was reported that the Transvaal Provincial Administration had agreed to accept this retiring age, except in very special circumstances. *Noted.*

(*k*) *Diversion of Telephone Calls:* It was reported that the Committee had investigated this question at the request of the East Rand Branch. The technical difficulties were mentioned and it was reported that the Chief Engineer had stated that his

Department was unable to undertake this work at present owing to shortage of staff. *Noted.*

(*l*) *Retiring Age of Medical Women:* It was reported that the retiring age in the Public Service for both men and women was now 65 years. Members who had joined the Service prior to 1955 retained the option of retiring at the former age limit of 60 years. As far as the Provincial Administrations were concerned, the retiring age for both men and women in the Transvaal and Cape was 65 years, while in Natal and the Orange Free State men retired at 65 while women retired at 60 years. *Noted.*

(*m*) *Married Women in Parmanent Posts:* Extracts of letters were submitted, one being from the Private Secretary of the Minister of Health and the other from the Secretary of the Public Service Commission. Both letters stated that it was the policy of the Government not to employ married women in permanent capacities in the Public Service, and that no departure from this attitude was contemplated. *Noted.* The same attitude was found in the Natal Provincial Administration, while the Transvaal, Orange Free State and Cape Administrations employed married medical women in a permanent capacity. *Noted.*

(*n*) *Rates of Pay for Part-time Medical Officers Employed in Clinics Run by Local Authorities:* Dr. Struthers stated that his Committee was still considering this matter and that it considered the scales at present paid to the incumbents of these posts as being inadequate. The matter was to be taken up with the authorities concerned. *Noted.*

(*o*) *Native Law Amendments Bill:* Dr. Shapiro stated that this Bill contained certain sections dealing with the attendance of Africans at hospital out-patient departments. He proposed, seconded by Dr. Gluckman, that the matter be referred to the Parliamentary Committee as a matter of urgency. Council *Agreed.*

Dr. Struthers then moved the adoption of the Report of the Parliamentary Committee as a whole. This was *Carried with Acclamation.*

The Chairman thanked Dr. Struthers and the members of the Committee for their continued work on behalf of the Association. *Acclamation.*

NOTICES OF MOTION

97. *Notice of Motion—Contract Practice Policy:* The Chairman reminded Council of the resolution which had been taken at the Council meeting in April, 1956 (Minute 25(*e*)), reading: 'That the new Central Committee for Contract Practice, when appointed, shall consider the setting up of a tariff of minimum fees as a guide to the Branches and on which the Branches could base loadings for the various parts of their Branch areas.' He stated that the Central Committee for Contract Practice had reported at the last meeting that it was unable to set up such a tariff, and that at that time notice of motion had been given over the names of Dr. Struthers and Dr. Shapiro that the resolution in Minute 25(*e*) of April, 1956, be rescinded.

Dr. Struthers moved accordingly. Without discussion Council *Agreed Nem. Con.* to the rescission of the resolution.

98. *Notice of Motion—By-Law* 58: The Secretary reported that replies had been received from four Branches, all agreeing to the amendment as set out.

On the matter being put to the vote, Council *Agreed Nem. Con.* that By-Law 58 be amended accordingly. The By-Law will in future read as follows:

'The Head Office and Journal Committee shall have power to deal with all matters affecting the administration of the *Journal* and Head Office, provided that without the prior consent of the Federal Council or of the Executive Committee the Head Office and Journal Committee shall not—

(*a*) incur any extraordinary expenditure, or

(*b*) determine or vary the salary scales, remuneration or allowances of any official whose total remuneration exclusive of allowances exceeds £1,000 per annum, or

(*c*) mortgage, sell or purchase any immovable property on behalf of the Association.'

HONOURS

99. *Bronze Medal—Mr. B. A. Armitage:* The Secretary read a recommendation and citation received from the Natal Inland Branch.

A ballot vote was taken, Drs. Combrink and J. G. A. du Toit acting as scrutineers. As a result the Chairman announced that Mr. Armitage had been awarded the Bronze Medal. *Noted with Acclamation.*

100. *Bronze Medal—Dr. M. Shapiro:* The Secretary read a recommendation received from the Southern Transvaal Branch.

A ballot vote was taken, Drs. Combrink and J. G. A. du Toit acting as scrutineers. The Chairman announced as a result that the Bronze Medal had been awarded to Dr. Shapiro. *Noted with Acclamation.*

HEALTH SERVICES

101. *Cape Province:* Dr. Sichel, Chairman of the Cape Augmented Executive Committee, reported that there had been only one meeting of the Liaison Committee between the Medical Association and the Provincial Administration since the last meeting of Council. The following matters had been dealt with:

102. *Introduction of Charges for Hospital Services:* Dr. Sichel reported that it had been pointed out at the meeting of the Liaison Committee that as the ability of patients to pay for hospital care was receiving the attention of almoners, it seemed to be unnecessary for persons paying less than 5/– per day, who were mostly non-Europeans, to be given the additional trouble of securing certificates to the effect that they were unable to pay for medical attention. In the circumstances it had been agreed that for those persons paying less than 5/– per day it would not be necessary for the Medical Superintendent of a hospital to insist on a certificate of inability to pay for medical attention, it being understood that persons paying less than 5/– per day would be unable to choose their own doctor. *Noted.*

103. *Medical Examination and Treatment of Nurses:* Dr. Sichel reported that it had been agreed that the routine medical examination of nurses was the responsibility of the Medical Superintendent of a hospital; that if he delegated this duty to others it should not be delegated to interns. In regard to the treatment of sick nurses, it had been agreed that where necessary they should be admitted to hospital as non-paying cases and as such would receive the attention of the honorary staff. *Noted.*

104. *Post of Radiologist:* Dr. Sichel stated that it had been reported that advertisements regarding the post of honorary radiologist to the Conradie Hospital had not resulted in any applications and that consequently a post of paid part-time radiologist had been created. *Noted.*

105. *Provincial Hospital, Port Elizabeth:* Dr. Sichel stated that it had been reported that the honorary staff at the Provincial Hospital, Port Elizabeth, had passed a resolution reading: 'That it is the opinion of the honorary staff of this hospital that the honorary system should be abandoned in favour of a system of employment of medical staff on a paid sessional basis.' It had been generally agreed that if this resolution was carried out in regard to the Provincial Hospital, Port Elizabeth, it would sound the death-knell of the honorary system in the Cape Province. It was felt that this would be a great pity as the honorary system was one which had been jealously guarded in the Province for many years. *Noted.*

Discussion followed and Dr. Lane stated that the Cape Midlands Branch wished to avoid a full-time staff as far as possible and would prefer that part-time medical men be appointed to serve the hospitals on a sessional basis.

After further discussion Council *Agreed* that the matter be referred back to the Cape Augmented Executive Committee for such action as may be considered necessary.

106. *Central Hospitals Committee (Cape):* Dr. Sichel reported that the period of office of Dr. F. R. Luke as a member of the Central Hospitals Committee had terminated on 28 February, 1957. In accordance with the usual procedure, the Branches in the Cape had been asked to nominate members to fill the vacancy. The only nomination received had been that of Dr. F. R. Luke for re-election, and accordingly his name had been sent forward to the Provincial Administration.

Council *Confirmed* this appointment.

Dr. Sichel then moved the adoption of the Report of the Cape Augmented Executive Committee, which was *Carried Nem. Con.*

107. *Transvaal:* Dr. Struthers presented the Report of the Transvaal Augmented Executive Committee. He referred members to the extensive reports which were contained in the Annexures to the Agenda. The following items were considered:

108. *Medical Ethics Conference:* Dr. Struthers referred to a conference which had taken place between members of the Com-

mittee and members of the Executive Committee of the S.A. Medical and Dental Council, at which the President of the Medical Council had stated that the Council had not changed its views concerning the principles which had been set out at the conference which had taken place in 1955. He indicated that the Association would be informed of the final decision of the Medical Council in regard to any amendments which might take place. *Noted.*

109. *Relationship of S.A. Institute for Medical Research and Medical Profession in the Provision of Medical Services to the Public:* It was reported that a conference had taken place which had led to an amicable settlement being reached between the Association and the Institute. The Committee was satisfied that there were no outstanding problems which could not be adequately solved by mutual discussion. *Noted.*

110. *Hospital Appointments in Transvaal:* It was reported that the Committee had been informed by the Southern Transvaal Branch that appointments were being made without advertisement. The Committee had interviewed the Director of Hospital Services in the Transvaal and had been informed that all part-time appointments were advertised and that in regard to full-time staff interns were appointed by hospital boards, clinical assistants and casualty officers were only appointed after advertisement, temporary appointments were made without advertisement, new appointments were always advertised and appointments which could be filled by promotion within the Service were only advertised departmentally. *Noted.*

111. *Medical Representation on Boards of Transvaal Non-Teaching Hospitals:* It was reported that the East Rand Branch had informed the Committee that a new method of electing medical representatives to Hospital Boards had been introduced. According to this method, the nominations were now made by magistrates and not by Branches of the Medical Association. Following representations, it had been agreed by the Administrator-in-Executive Committee that the method of appointing medical practitioners to Hospital Boards would revert back to the old procedure. *Noted.*

112. *Radiographic Services in the Transvaal:* It was reported that arrangements were being made whereby certain health services were obtaining X-ray plates from Transvaal Provincial hospitals on the payment of a small fee. These plates were not accompanied by any radiological report. The Committee was not prepared at this stage to make any recommendation.

After discussion Council *Agreed* that the matter be referred back to the Transvaal Augmented Executive Committee for further investigation.

Dr. Struthers then moved the adoption of the Report of the Transvaal Augmented Executive Committee, which was *Carried Nem. Con.*

113. *Natal:* Dr. Deale stated that the Natal Augmented Executive Committee had nothing to report; but Dr. Thompson enquired regarding the treatment of mental hospital cases in Pietermaritzburg. He stated that his Branch had been informed that all mental hospital patients would be dealt with in general hospitals as hospital cases.

After short discussion it was *Agreed* that Dr. Thompson should raise this matter with Dr. Grant-Whyte as Chairman of the Natal Augmented Executive Committee.

114. *Orange Free State:* Dr. Theron, Chairman of the Orange Free State Augmented Executive Committee, reported that the Provincial Administration had decided to introduce a new system of payment for services rendered by medical practitioners in the Province. This would be worked on the basis of 'per bed' rather than 'per capita', and the amounts payable per bed would vary from £17 10s. 0d. to £20 per annum. Discussions had taken place and the question of the payment of part-time staffs had now been settled to their satisfaction. *Noted.*

115. *S.A. Medical Congress, Durban, September* 1957: Dr. Rossiter reported that arrangements were adequately in hand. He said that it had been agreed to hold four Plenary Sessions, and quite a number of distinguished guests were expected which would add greatly to the tone of the discussions.

His report was *Noted with Acclamation.* The Chairman asked Dr. Rossiter to convey to the responsible Organizing Committee Federal Council's good wishes for a very successful Congress.

116. *Congress in Lourenco Marques:* The Secretary reported that there was the possibility of an invitation coming from Lourenco Marques to hold a Congress in that city in 1959. He stated that other conferences were being held in Lourenco Marques in 1958 and 1960. No definite decision had yet been made in this connection. *Noted.*

MATTERS REFERRED TO OR BY S.A. MEDICAL AND DENTAL COUNCIL

117. *Medical Council Enquiry—Dr. B.R.:* Dr. Struthers stated that he had been responsible for raising this matter as it now appeared that the S.A. Medical and Dental Council had stated that they wished the Association to understand that as a Council they did not have to undertake any legal expenses in connection with a complaint of the kind under review.

Dr. Shapiro stated that no finality had yet been reached regarding this matter. The question arose as to whether the Association should take legal action where the Medical Council refused to do so.

Further discussion followed, and eventually Council *Agreed* that the matter should be left to the Secretary for consideration.

MATTERS REFERRED TO OR BY BRANCHES

118. *Poliomyelitis Vaccine:* The Chairman drew attention to the considerable correspondence and memoranda contained in the Annexures, and the Secretary stated that the Executive Committee had agreed to recommend to Council 'That a statement be issued on three points: (1) To urge that sufficient vaccine be made available for all patients wishing to receive it; (2) that the distribution be equitable if the vaccine is in short supply; (3) that a doctor should be able to decide for his patient whether he will use imported or local vaccine.'

Discussion followed, and it was proposed by Dr. Schaffer, seconded by Dr. Struthers and *Resolved Nem. Con.* that the recommendation of the Executive Committee be accepted.

119. *Registration of Medical Auxiliaries:* The Secretary referred to a letter from the S.A. Medical and Dental Council on this subject, stating that it had been sent to the Branches for comment. He then outlined the comments which had been received from certain of the Branches.

After short discussion it was proposed by Dr. Shapiro, seconded by Dr. Purcell and *Resolved* that the matter be referred to the Parliamentary Committee in order that a memorandum may be prepared as a basis for discussion by the Branches.

120. *Immunization Against Tetanus:* A resolution from the Cape Western Branch was submitted, in which it had been decided 'to request that such steps as may be required to encourage and extend the practice of active immunization against tetanus should be taken. In view of the serious nature of the disease and the increasing number of severe reactions that are occurring following the use of tetanus anti-serum, it is felt that immunization against tetanus should receive the same propaganda and encouragement by public health authorities as is accorded to diphtheria and pertussis.'

The Secretary stated that the Executive Committee had agreed to recommend to Council that the resolution of the Cape Western Branch be supported and forwarded to the Secretary for Health. Council *Agreed.*

121. *Ambulance Service Outside Municipal Areas:* A resolution from the East Rand Branch was submitted, reading: 'That Federal Council take steps to urge local authorities to provide adequate ambulance service outside the Municipal areas where necessary.'

It was proposed by Dr. Shapiro, seconded by Dr. Turton and *Resolved,* 'That as this is a Provincial matter, it be dealt with by the Augmented Executive Committee in the Transvaal.'

122. *Visiting Lecturers' Trust Fund:* A resolution from the Natal Coastal Branch was submitted in regard to the establishment of a Visiting Lecturers' Trust Fund for the purpose of defraying the travelling expenses of distinguished visitors from overseas. It was pointed out that the resolution referred particularly to visitors at Congresses, but that it might be necessary at times to subsidize visitors who might be visiting the Union at times other than those at which Congresses were held.

Dr. Agranat stated that in view of the state of the finances of the Branches, this question should be deferred.

After discussion it was *Agreed* that the matter be deferred until the next meeting of Council.

123. *Indigent Litigants:* A letter from the Natal Coastal Branch was submitted, covering a request from the Incorporated Law Society of Natal that doctors should make no charge for medical certificates where a patient had been granted the right by the court to sue *in forma pauperis,* it being understood that the right would

be reserved to charge for services should the suit for damages be successful.

The Secretary stated that this matter had been referred to Branches, and the replies so received were made known to Council. As not all the Branches had replied, the Secretary suggested that a reminder should be sent to the defaulting Branches and that the matter be debated at the next meeting of Council. Council *Agreed.*

124. *Operations by General Practitioners in Nursing Homes:* The Chairman referred members to the correspondence and memoranda submitted by the Natal Coastal Branch which appeared in the Annexures, and reminded members that this matter had come before Council on a previous occasion.

The Secretary stated that the Executive Committee had considered this matter and had agreed to recommend to Council 'That the Federal Council inform the South African Nursing Council that it considers that the matron is not entitled to take the law into her own hands by refusing to allow a doctor to operate in a nursing home. That if a matron considers that a doctor is not capable of, or is insufficiently trained for, work which he is undertaking, she is entitled to report him to the South African Medical and Dental Council for such action as may be necessary under the Council's rules.' The recommendation of the Executive Committee was put to the vote and *Carried.*

125. *Amendments to Constitution of Southern Transvaal Branch:* The amended Constitution was submitted, and the Secretary stated that the Executive Committee had agreed to recommend to Council that the amended Constitution of the Southern Transvaal Branch be approved. Council *Agreed.*

126. *Contract Practice in Southern Transvaal Branch Area:* A resolution from the Southern Transvaal Branch was submitted, stating: 'That this meeting considers that it is in the interests of the medical practitioners in the Southern Transvaal to revert to the position where the Southern Transvaal Branch of the Medical Association of South Africa had control of all Contract Practice affecting its members, and that the Federal Council be advised that in terms of its original agreement to a Union-wide Schedule for Medical Aid Societies this Branch gives one year's notice to withdraw therefrom.' The Chairman reminded members that this had been noted at the meeting of Council held in October, 1955, and that the Southern Transvaal Branch was now stating that it wished to give effect to the resolution.

Dr. Shapiro stated that in view of the new arrangements which had been made in regard to Contract Practice and the machinery which might be set up for negotiations, he did not feel that the Southern Transvaal Branch should press the matter at this stage. In the circumstances he proposed the consideration of the matter be deferred until the next meeting of Council. Council *Agreed.*

127. *Editorial in S.A. Medical Journal:* A letter from the Southern Transvaal Branch was submitted, drawing attention to an editorial article in the *Journal* of 8 December, 1956.

Dr. Gluckman stated that a paragraph towards the end of the article had given rise to headlines in the Johannesburg lay press, as it referred to the possibility of a State medical service.

Council *Agreed* that the letter be *Noted.*

MATTERS REFERRED TO OR BY GROUPS

128. *Orthopaedic Surgeons' Group—S.A.R. & H. Sick Fund—Orthopaedic Services:* Mr. G. T. du Toit said that Council had agreed to the orthopaedic surgeons' services to the S.A.R. & H. Sick Fund being continued for a period of one year, and that the contract had now run for ten months, so that the position should come up for review. He stated that the Group felt that further negotiations should be carried on by the Central Committee for Contract Practice, and he moved accordingly.

Council *Unanimously Resolved* that the question of the services of orthopaedic surgeons to the Railways and Harbours Sick Fund be dealt with by the Central Committee for Contract Practice.

129. *Pathologists' Group—Pathological Laboratory Services:* A letter was submitted from the Pathologists' Group protesting against the making of Rhesus factor investigations a free service by Government laboratories.

Dr. Shapiro stated that the Government had recognized that Rhesus factor investigations in pregnancy were important public health measures and should be made freely available to the public. He considered that it was an admirable action on the part of the Government.

Dr. Gluckman stated that he agreed with the views expressed by Dr. Shapiro, and he proposed, seconded by Dr. Landau, that the request of the Pathologists' Group be not agreed to. Council *Resolved* accordingly.

130. *General Practitioners' Group—Fees for General Practitioners, with special Reference to Medical Aid Societies:* The Chairman referred members to the correspondence in the Annexures.

Council *Noted* that this matter had already been dealt with under the Report of the Central Committee for Contract Practice.

MATTERS REFERRED TO OR BY AFFILIATED ASSOCIATIONS

131. *British Medical Association Annual Meeting, July 1957:* The Secretary reported that at the last meeting of Council he had been appointed to be the delegate at this meeting, as he was to have attended the British Commonwealth Medical Conference; but as he would not be going, it was for Federal Council to appoint someone else.

After short discussion Council *Agreed* that Dr. Grant-Whyte be asked to represent the Association at the British Medical Association Annual Meeting, failing whom Dr. Wagner be asked to be the Association's representative.

OTHER BUSINESS

132. *Pathologists' Group—Reduced Subscriptions for Full-time Medical Personnel:* The Secretary said that at this stage he would not suggest that the matter was urgent, nor had a final recommendation been received in time for this meeting. *Noted.*

133. *National Conference Convened by National Cancer Association of South Africa:* The Secretary stated that this was to be held in April, 1957, in Johannesburg. The Cancer Association had requested that the Medical Association should contribute towards the discussion.

Council *Agreed* to consider the matter as urgent.

It was proposed by Dr. Shapiro, seconded by Dr. Alexander and *Resolved* that the matter be referred to the Southern Transvaal Branch.

134. *Contract Work in Radiology:* The Secretary reported that he had received a long memorandum in this connection.

The matter was not considered by Council to be urgent.

135. *Date and Place of Next Meeting of Council:* The Secretary stated that the Executive Committee had agreed to recommend to Council that the next meeting of Council be held in Durban towards the end of the week preceding the Congress, and that the statutory Annual General Meeting be held in the morning preceding the opening of the first Council session.

The Chairman suggested that Council accept these provisional arrangements and leave the final choice of dates to the Executive Committee. *Agreed.*

136. *Thanks:* The Chairman thanked members for attending the meeting. He stated that as this was the last meeting of the existing Council, he felt that it would be appropriate to say good-bye to Dr. J. H. Harvey Pirie who had remained on the Council for the last twelve years as Immediate Past Chairman. In spite of ill-health, Dr. Harvey Pirie's contribution to the Council had been considerable. Council accorded a vote of thanks to Dr. Pirie *with Acclamation.*

Dr. Alexander proposed a vote of thanks to the Chairman, which was *Carried with Acclamation.*

The meeting ended at 6.45 p.m.

WMA REPRESENTED AT WORLD HEALTH ASSEMBLY

The World Medical Association, representing 700,000 doctors of the world, had a delegation at the 10th World Health Assembly when it met in Geneva, Switzerland, on 7 May 1957. The members of the delegation included Dr. Jean Maystre, Official Liaison Officer of the WMA to the WHO, Dr. Louis H. Bauer, Secretary General of the WMA and Dr. Rolf Schloegell, Secretary of the Social Security Committee of the WMA.

The WMA presented the opinion of the doctors of the world

at the Technical Discussion of the Health Assembly on the topic *The Role of the Hospital in the Public Health Programme*. A Council committee of the WMA had prepared a paper entitled *The Practising Doctor's Evaluation of the Role of the Hospital in the Public Health Programme*, which had been transmitted to the WHO. This document stressed the following points:

Health care is an undertaking requiring a team approach—the team to be composed of doctors, dentists and their ancillary personnel as well as certain agencies such as professional organizations, voluntary and official health agencies, social welfare agencies and government.

The prime consideration in the whole programme is, or should be, the public.

The general practitioner is the doctor best qualified to offer continuity of health care. He should have free access to the hospital to continue the patient's health care and to provide him with the opportunities of continuing medical education provided through hospital meetings and research.

A hospital is an institution and cannot replace an individual or group of individuals without medical care becoming depersonalized and mechanical.

The hospital achieves and holds its reputation almost exclusively by virtue of the reputation of its staff.

Hospitals cannot function without doctors. Doctors cannot practise modern scientific medicine without hospitals. One of the first questions to be answered is: *Who* is to determine how medicine is to be practised both in hospitals and elsewhere?

The moment that full reliance for individual and family responsibility is placed on government an essential element in 'mental and social well-being' is undermined.

FINAL APPEAL FOR THE PROFESSOR DRENNAN PRESENTATION FUND

Professor M. R. Drennan, head of the Department of Anatomy at the University of Cape Town for 40 years and doyen of its Medical Faculty, retired last year. His distinguished academic career is known not only to the thousands of medical students who passed through his Department during this period but also to every medical man and academician in Southern Africa and beyond.

In 1955 a Fund was inaugurated by an Appeal Committee (Mr. F. D. du Toit van Zyl, Prof. T. Muller, Prof. M. van den Ende, Prof. F. Forman, Prof. J. A. Keen, Prof. J. T. Louw, Prof. J. H. Louw, Prof. D. Slome, Prof. S. Zuckerman, Prof. H. J. Zwarenstein, Dr. R. Wolff, Mr. J. A. S. Marr, Mr. P. J. M. Retief, Mr. W. Schulze, Mr. W. Wilkie, Dr. J. H. van der Horst, Dr. Charles Shapiro, Dr. C. S. Grobbelaar, Dr. E. N. Keen and Dr. R. Singer) with the object of making a suitable presentation to him. The Committee is convinced that all his colleagues and former students will wish to honour him for the encouragement and inspiration which he has given to them for so many years.

The Committee is making this final appeal as it wishes to make the presentation shortly, and those who wish to contribute to the Fund are requested to make their cheques payable to The Professor Drennan Presentation Fund, c/o The Alliance Building Society, P.O. Box 1582, Cape Town.

IN MEMORIAM

MAURICE PESKIN, M.D.

Dr. H. A. Shapiro, Johannesburg, writes: We deeply regret to record the death of Dr. Maurice Peskin, a prominent and distinguished member of the medical profession as well as of the Medical Association of South Africa.

Maurice Peskin

He was a member of the Branch and the Federal Council for the last 6 years. He served on the Executive Committee of the Branch from 1953 until his untimely death. He was a member of the Clinical Agenda Committee (1953-56); of the Benevolent Fund Sub-committee (1953-56) the Telephone Sub-committee (1953-55). He also served on numerous other committees, e.g. the Ethical Committee and the Press Liaison Committee, and he was the Association's representative on the Mental Hygiene Society of the Witwatersrand.

Although his health had suffered several setbacks in recent years, Dr. Peskin pursued his work in his private practice as well as in the Branch with undiminished vigour and enthusiasm.

We feel his loss all the more, as he had only recently assumed office as Vice-President of the Branch this year.

Dr. A. L. Agranat, Johannesburg, writes: Maurice Peskin's death came as a severe shock to his many friends. Although those closer to him realized that he had been in precarious health for a long time, it was difficult to be fully aware of this when in his presence, even in the last weeks of his life when he made a temporary recovery from another very severe episode in his prolonged illness. His animated and genuine interest in the welfare of his colleagues and in the Medical Association very soon brushed aside any reference to his own health, and it was at times an effort to realize that he was a patient. His indomitable courage and the patience with which he faced his illness for a number of years was almost incredible. Those of us who knew how courageous he was will remember how he would place a tablet under his tongue to brace himself and relieve pain before addressing meetings, both in the Councils of the Association and at Branch Meetings.

Medical Association work was very near to him, and he never flinched from accepting the many onerous duties which inevitably fell on him. His clarity of mind was always evident when he marshalled his facts to present a case at Council deliberations. His sincerity and conviction in any discussion always commanded attention and respect for the case he was presenting.

One outstanding tribute I would also like to pay to Maurice's memory was the fact whether anyone else's own views agreed with his or not, there was never any personal animosity, and under all circumstances he remained a sincere friend and staunch colleague. His unselfishness was reflected in everything he did, and he never sought any aggrandisement or honours. His modesty was exemplified when our Branch Council unanimously elected him as Vice-president of the Southern Transvaal Branch, an honour which was small reward for his self-sacrificing work, and which he was at first reluctant to accept because he feared that his health would not allow him to do full justice to the onerous duties of occupying the chair during his term of office as President. It is perhaps a small consolation to know that he confided to

one or two friends his sincere appreciation of this action by all members of Branch Council.

I shall not refer in this tribute to his many other qualities except to mention that he was held in the highest esteem in his professional work, as one of the senior and leading neuro-psychiatrists in Johannesburg. Many demands were made on him for his wise counsel and guidance by other communal bodies, to whom he also rendered unstinting service with never a thought of himself. He was one of the first to enlist during the last World War, during which his service was marked by merit and devotion. It was during those days that the first indications of his fatal illness appeared. This, however, did not deter him from undertaking the most strenuous duties in an honorary capacity in subsequent years.

Maurice Peskin will be sadly missed by his many friends, and the Southern Transvaal Branch as well as the Medical Association of South Africa owe a deep debt of gratitude to the affectionate memory of our courageous, wise and self-sacrificing colleague and sincere friend. Sincere sympathies are extended to the widow and children.

UNIVERSITY OF NATAL : STATEMENT BY MEDICAL STAFF

On 2 May 1957 a meeting of members of the Academic Staff of the Faculty of Medicine was held. Seventy-six full-time and part-time members of the Academic staff were present at the meeting and the following statement was unanimously approved and issued for publication:

'We, the academic staff, teaching in the Faculty of Medicine of the University of Natal and assembled at this meeting on 2 May 1957:

'1. Have taken note of the considerations which the Minister of Education, Arts and Science requested the Dean on 22 March 1957, to place before us;

'2. Have studied the provisions of the revised Separate University Education Bill which was introduced in the House of Assembly on 8 April 1957; and

'3. Have given consideration to the statement made by the Minister of Education, Arts and Science in the House of Assembly on 9 April 1957 conveying the intention of the Government to transfer the control of our Faculty to the Department of Education.

'The revised Separate University Education Bill will set a new pattern for the higher education of African, Indian and Coloured persons in our country.

'As University teachers we find this pattern unacceptable and we believe that it will have adverse effects on higher education in general and on medical education in particular for our African, Indian and Coloured peoples.

'In view of the Minister's statement that it is the intention of the Government to remove our Faculty from the University of Natal, and because we believe that the new pattern for higher education will be applied to our Medical School at some time more convenient to the Government, we find that our previously stated objections to the legislation have in no way been removed and our fears in regard to the future of our School have, in fact been confirmed.

'We have now to state that our attitude as expressed in previous resolutions in regard to our continued service in the Medical School remains unaltered, and we are unable to give an assurance that all or any of us will be prepared to retain our posts until such time as the control of our Medical School is removed from the University of Natal and placed directly under the State.

'This decision has been taken because we believe that we will be unable to carry out our academic and professional work and fulfil our responsibilities to our students under the conditions which will be established for the higher education of African, Indian and Coloured persons when the Separate Education Bill of 1957 is enacted.'

DIPHTHERIA IN THE TRANSKEI

BY OUR PARLIAMENTARY CORRESPONDENT

The Minister of Health, Mr. J. H. Viljoen, in the House of Assembly replying to a question by Mr. T. G. Hughes (Transkeian Territories), said there was an unusually high incidence of diphtheria in some Transkeian districts. During the 4 weeks ended 27 April, 209 cases were reported from the Transkeian and Border districs.

The districts mainly affected were Engcobe, where 91 cases had occurred; Matatiele, 35 cases; Nqamakwe, 23 cases; Queenstown, 13 cases and St. Marks, 7 cases.

'An emergency hospital was opened in Matatiele and in other districts cases were isolated in mission hospitals', said Mr. Viljoen. 'In addition, vigorous immunization campaigns were conducted and some 30,000 persons were immunized against the disease during past months. The outbreaks now appear to be under control and only 15 patients remained in the emergency hospital at Matatiele at the end of last month.

'It may be pointed out', said Mr. Viljoen, 'that immunizing material against diphtheria is provided free of charge by my Department to local authorities and district surgeons, and parents are constantly being urged to have their children inoculated against the disease. I wish to take this opportunity of once again appealing to parents to ensure that their children are not exposed to unnecessary danger by neglecting to have them inoculated against diphtheria.'

PASSING EVENTS : IN DIE VERBYGAAN

Chas. F. Thackray (S.A.) (Pty.) Ltd. advise that their Cape Town office has now moved into new premises, 108-110 Medical Centre, Heerengracht, Cape Town.

* * *

At the Annual General Meeting of the General Practitioners Group (Cape Western Sub-group) held on 25 April 1957 at Cape Town, the following office bearers of the Sub-group were elected: *Chairman*, Dr. George Paterson; *Vice-chairman*, Dr. Charles Shapiro; *Hon. Secretary*, Dr. Norman Levy; *Assistant Hon. Secretary*, Dr. Sidney Kiel; *Treasurer*, Dr. Morris Helman.

REVIEWS OF BOOKS : BOEKRESENSIES

SNAKES

Snakes—Mainly South African. By Walter Rose. Pp. xvi + 213. 89 Illustrations. 18s. (6d. postage). Cape Town: Maskew Miller Limited. 1956.

Contents: 1. Reptiles in General. 2. The Way of the Serpent. 3. Sense and Sensibility. 4. What and How a Snake Eats. 5. Reproduction. 6. Enemies and Protections. 7. Friends or Foes? 8. Is it Poisonous? 9. Venom, To Kill or Cure. 10. Degenerates. 11. The Python. 12. Fangless Snakes. Colubrinae. 13. Oesophageal Teeth. Dasypeltinae. 14. Back-fanged Snakes. Boiginae. 15. Hooded Death, Elapidae. 16. Other Front-fanged Snakes, Elapidae continued. 17. Sea Snakes. Hydrophiidae. 18. Adders. Viperidae. 19. Myth or Fact? 20. Selected Snake Stories. 21. Brief Encounters.

Dr. Walter Rose is well-known to most of us through the correspondence columns of our daily newspapers and one has

often read in his letters his earnest pleas against the indiscriminate killing of harmless snakes. Which are the harmless ones? That is for us laymen to find out. Most of us are so frightened of these reptiles that we give the whole of them a wide berth. In this book Dr. Rose sets out to help us in the identification of the South African snakes.

The work contains interesting descriptions of the anatomical structure and habits of these frightening but beautiful animals. There are numerous fine photographs. The scientific information is liberally interspersed with entertaining anecdotes culled from wide sources.

Most medical men with any sort of interest in natural history will derive a great deal of pleasure and entertainment from this book.

E.M.S.

SYNOPSIS OF UROLOGY

Synopsis of Genitourinary Diseases. Sixth Edition. By Austin I. Dodson, M.D., F.A.C.S. and J. Edward Hill, M.D. Pp. 330 + 124 Illustrations. £2 1s. 6d. St. Louis: The C. V. Mosby Company. 1956.

Contents: I. Urologic Diagnosis. II. Instruments, Minor Urologic Procedures and Internal Medication. III. Anatomy of the Urogenital Tract. IV. Congenital Anomalies. V. Nontuberculous Infections of the Urinary Tract. VI. Nontuberculous Infections of the Urethra. VII. Nontuberculous Infection of the Genital Tract and Disturbances of the Male Genital Function. VIII. Tuberculosis of the Urogenital Tract. IX. Injuries. X. Calculi and Calculous Disease. XI. Movable Kidney and Hydronephrosis. XII. Obstruction and Neurogenic Dysfunction of the Bladder. XIII. Hydrocele, Varicocele, Hematocele, Spermatocele. XIV. Tumors.

This book is of small size, and can fit into one's pocket. It is well bound, and the subject matter is well arranged.

As the title suggests, it is merely a synopsis of urological conditions, and as such is not of much use to the man who wants to gain detailed knowledge of his subject. In fact, contentious points are raised, which the individual urologist might argue against.

For the student, however, and for those of us who have not got a great deal of time at our disposal for detailed reading and yet are often confronted with the need to make a differential diagnosis and institute safe treatment until the patient can be examined in greater detail, this book is of great value. Most urologic conditions are mentioned, some rather briefly, but in a way that reminds us of their existence.

It would have been of great help to the occasional operator if a few tips had been given in certain cases; e.g. in suspected rupture of the bladder, a cystogram, followed by an evacuating cystogram, will give the diagnosis immediately.

Despite a few criticisms of this nature, this book will be referred to fairly often if bought for the shelf of the doctor who does not do urology all day and every day.

J.D.J.

CORRESPONDENCE : BRIEWERUBRIEK

RESIGNATION OF NON-EUROPEAN R.M.OS.

To the Editor: I was most disturbed to read in the lay press recently, of the resignation of eight non-European R.M.Os. at Edendale Hospital because of the discriminatory salaries offered to them as compared with those of the European R.M.Os. doing exactly the same work.

These non-European doctors have the same qualifications as the European doctors and have been involved in the same expense to gain these qualifications, and thus are entitled to equal pay for equal work. I can see no valid reason for this discrimination and I am sure many of my colleagues will agree with me.

This is, I feel, a strong case where our Association should step in and make a strong protest to the Natal Provincial Administration.

J. L. Beckh

P.O. Creighton
Natal
2 May 1957

GENERAL PRACTITIONERS AND FEDERAL COUNCIL

To the Editor: Is private practice headed for bankruptcy? This would appear to be the case—*vide* the report of an *ad hoc* Committee on the Economics of Medical practice which was published in the *Journal* of 20 April 1957, pages 390-391.[1]

A few quotations from this report are very thought-provoking:

> 'The profession has been conscious that in their practices the proportion of medical aid patients to private patients has grown exceedingly in the last few years. . . . It is apparent to most doctors that unless a comprehensive prepayment plan is produced, the next few years will see tremendous changes in the pattern of practice so that many practitioners may go near to bankruptcy.'

But now is the time to organize our own defence against this threat, because the welfare and happiness of the general practitioner will depend entirely on his own efforts and on his participation in the business affairs of the Medical Association.

As you know, the Federal Council controls the affairs of the Medical Association and, things being what they are, the majority of members of Federal Council are specialists. At the last election for Federal Council in the Cape Western Branch, at least 4 general practitioners stood but only one polled a sufficient number of votes to gain a seat. As long as general practitioners abstain from voting or vote for specialists only—so long will our economic welfare depend on the crumbs from the rich man's table.

In the same issue of the *Journal*[2] (page 388) we read of the negotiations between the Advisory Council of Medical Aid Societies and the Central Contract Committee of Federal Council:

> 'The new tariff was accepted by Federal Council at this meeting. . . . It includes a general increase in *specialist fees* . . .'

'New' consultation and visiting fees for general practitioners are also quoted,[2] viz. 12s. 6d. and 15s. 0d. To say that these fees are new is fallacious as they have already been in operation for the past 12 months.

Thus it would appear that whereas there has been 'a general increase in specialist fees' the only real increase in general practitioner fees is from 23s. 6d. to 25s. 0d. for a night call and other minor adjustments. Further it is quoted by Dr. Struthers,[2] immediate Past President of the Association and Vice-chairman of Federal Council that of 4,000 doctors in South Africa 1,000 (25%) are specialists and 3,000 (75%) are general practitioners. Of medical aid fees 45% go to specialists and 55% to general practitioners. Therefore 25% of the medical population are getting 45% of the money while the remaining 55% of the money has to be divided among 75%.

How can we assure that the general practitioner, who comprises 75% of the membership of the Association, can pull his full weight in the affairs of the Association?

1. By general practitioners being prepared to accept nomination for office on Federal Council.
2. By the general practitioner exercising his vote in such a way so as to ensure that the 75% of the medical population have adequate representation on Federal Council.

It is the intention of the General Practitioners' Group (Cape Western Sub-group) to nominate 7 general practitioners to stand for Federal Council in the forthcoming elections in July. These candidates will succeed in this election if general practitioners do their duty and vote for them. The general practitioner viewpoint will then get adequate ventilation in Federal Council.

The Cape Western Sub-group of the General Practitioners' Group consider this matter of such importance that they earnestly recommend members of other Branches of the Association to take similar steps.

Chairman
Cape Western Sub-group, General Practitioners Group, Medical Association of South Africa.

121 Forest Drive
Pinelands, Cape
8 May 1957

1. Report (1957): S. Afr. Med. J., **31**, 390.
2. Report (1957): *Ibid.*, **31**, 388.